

# Sports Psychiatry

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# The complexity of sports psychiatry and sports medicine

## Looking beyond the biopsychosocial model

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A comprehensive treatment of athletes requires not only a focus on preventive measures and medical treatments, but also calls for an integrated attention on mental health, often understood as the biopsychosocial approach to health care [1]. This issue of Sports Psychiatry focuses on the overlap of sports medicine and sports psychiatry, while expanding its scope to include critical social and cultural aspects.

Howarth et al. present in their analysis of prevalence rates of common mental health problems and associated psychosocial issues in elite swimmers the variety of consequences impacting the athletes' careers and life [2]. While overall, swimmers had lower rates of anxiety and depression, increased levels of career dissatisfaction were identified. The sports physician, as well as sports psychiatrist needs to be aware of the complexity of somatic and psychological signs and symptoms in the context of different disciplines, while being mindful of the athlete's background.

While it is crucial to focus on the psychosocial and medical factors of each athlete, it is essential to assess environmental factors impacting the individual. Glick and Zaccaria describe how culture, migration and other sociodemographic variables not only impact the way sport is being performed, but also how health issues are being presented [3]. Using basketball as an example, Glick and Zaccaria portray how changes in the game lead to changes in medical and psychological problems. A more intense and physical game results in increased orthopedic problems, while a higher frequency of interactions with teammates worsens stress and anxiety. This knowledge and awareness need to be integrated into medical-psychiatric practice.

All athletes are at risk for a variety of injuries, with injuries affecting their brain often having the most far-reaching consequences [4]. McCabe and Menon highlight the importance of paying close attention to concussion and more severe traumatic brain injuries in the context of cricket [5]. Besides the treatment of these injuries, health care providers need to be aware of boundaries within current assessment tools and recognize the importance of a multidisciplinary approach in managing sports related brain injuries. The engagement of the health care provider should not end there; medical experts should be at the forefront of education of athletes, coaches, and the general public.

In the context of shedding light on different factors influencing athletes, Begel's essay describes different varieties of racism in sports, including violent, systemic, and hidden forms of racism [6]. The impact of racism on athletes is overwhelming and contrasts the lack of studies focusing on the subject and health consequences. Tackling racism includes awareness and taking a stand against racism, not only within the medical encounter but also on a scientific and political level. The example of Vinicius Jr exemplifies how pervasive and destructive the effects of racism are on the individual athlete. Castellana et al. emphasize the importance for experts in sports psychiatry and sports medicine to speak out and become advocates for all athletes, especially for athletes belonging to a minority [7].


Educating a new generation of physicians on these topics is crucial. Edward's model of integrating sports psychiatry in a curriculum for sports and exercise medicine fellowship in Canada pioneers new ways to sensitizing future health care workers to look beyond the biopsychosocial model when treating athletes [8].

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# Do we need more scientific evidence for banning racist insults from soccer stadiums?

Vinicius Junior's reaction might be the answer

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Racism and mental illness are frequently intertwined and have a profound impact on individuals, communities, and societies at large. Racism, encompassing discrimination, prejudice, and systemic biases based on race, ethnicity, or cultural background, has far-reaching consequences for the mental well-being of those affected [1]. Experiencing racism can lead to significant psychological distress and trauma, contributing to the development or exacerbation of mental health conditions. The constant exposure to discrimination and racial biases can create chronic stress, triggering symptoms such as anxiety, depression, and post-traumatic stress disorder (PTSD). The emotional toll of racism can manifest in feelings of worthlessness, self-doubt, and a constant sense of being unsafe or unwelcome [2].

In his article “Tackling racism is sports psychiatry”, published in *Sports Psychiatry*, Begel [3] extensively reviewed the subject matter, including illustrative and clinical examples focusing on the consequences of racism in sports. However, the author's sample was limited to the US and did not examine the problem on a global level nor did he focus on the difficulties at soccer stadiums.

Notwithstanding the fact that all kind of interpersonal violence - including physical violence - between rival fans has always been common in soccer stadiums, there are indications of increasing racist insults over the last years. It is unclear, however, whether it is an actual surge or whether it has been more frequently registered by the ubiquity of smartphones and posting on social media.

In an effort of trying to inhibit racist insults in soccer stadiums, the FIFA Disciplinary Code 2019 edition, Art. 13, established that “Any person who offends the dignity or

integrity of a country, a person or group of people through contemptuous, discriminatory or derogatory words or actions (by any means whatsoever) on account of race, skin color, ethnic, national or social origin, gender, disability, sexual orientation, language, religion, political opinion, wealth, birth or any other status or any other reason, shall be sanctioned with a suspension lasting at least ten matches or a specific period, or any other appropriate disciplinary measure” [4]. Not only is racism banned from the stadium by FIFA, but discrimination of people based on race, color or ethnicities is prohibited in all forms in most countries according to United Nations [5].

Recently, the Brazilian soccer player Vinicius Jr was again victim of racist insults during the League Cup in Spain. After some supporters of the rival team called him “monkey” (“mono” in Spanish), Vinicius Jr reacted in an angry manner during the rest of the game and was eventually kicked off the field by the referee minutes later due to his behavior [6].

Racist incidents are usually minimized in the context of soccer specifically, as black athletes have always had strategies to cope with all kinds of rivals' provocations - for instance, eating the banana that was thrown at them. But when racism repeatedly targets the same player with the same kind of insults, even experienced elite athletes can break down and experience anxiety and depressive symptoms, as shown by Begel [3]. The author states, however, that “virtually no controlled studies have been published that measure the impact of racism on the mental health of Black athletes”.

But do we need more scientific evidence to ban racial insults from sports arena? How do racist insults differ from other common insults in soccer stadiums?

The answer might be in the episode regarding Vinicius Jr. Brazilian players are usually known for their ability, spontaneity, and dancing after scoring a goal. Some members of the Spanish sports press reported these behaviors as provocations justifying racial insults. These statements have astonished soccer lovers and journalists all over the world, asking for consequences and penalties for those racist statements [7].

Vinicius Jr's wrathful reaction against the racist remarks, sheds a light on the psychological distress associated with experienced racism, exposing the athlete to increased risk of developing mental disorders, as shown by the minority stress model, proposed by Meyer [8], originally created for the LGBTQ+ population but adaptable to any minority. The model provides an explanatory pathway for stress induced mental health and physical outcomes in minority populations [9]. The model argues that individuals from marginalized communities experience distal stressors (discrimination, stigmatization, etc.) and proximal stressors (internalized rejection, etc.), leading to allostatic changes and eventually to mental and physical illness [10].

The case of Vinicius Jr attends to the model, presenting a situation in which a black athlete victim of racism during a competition shows psychological distress directly associated with it. Although there is no sufficient data to establish that racist insults are always associated with mental disorder in athletes, we can conclude that no more scientific evidence is necessary to justify actions in sports arenas. We already have a lot of evidence how racism affects the mental health of people and we have a lot of information that it's not different in sports. Sport associations need to protect their athletes in stadiums from racisms and the consequences regarding their mental health. Nonetheless, further research is needed, not to reiterate the obvious consequences, but to more urgently alert sports federations to the abuse in stadiums.

Lastly, sports psychiatrists should be concerned with all social aspects that impacts life of professional athletes, not only those associated to biological causes or related to improving performance. They have a crucial role in early prevention and treatment of symptoms and mental health issues related to racism and other forms of discrimination and stigmatization. The unique skills of a sports psychiatrist enable them to focus on proximal stressors in treatment and therapy as well as distal stressors in being an advocate for their patients on a larger scale within the field of sports medicine and sports psychiatry. Especial when dealing with minority population athletes, psychological distress associated with racism should be actively assessed by sports medicine physician and treated in collaboration with sports psychiatrists.

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# The prevalence of common mental health problems and associated psychosocial issues in elite swimmers

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**Abstract:** *Introduction:* The mental health of elite athletes has been recognised as of great importance. There have been relatively few studies examining the prevalence of mental health problems in swimmers. None have commented on the range of psychosocial problems associated with mental ill-health. The aim of this study was to identify the prevalence of common mental health problems and psychosocial problems in elite swimmers. *Methods:* The study was conducted on a national swimming squad competing at the international level. All athletes (n=55) were invited to participate. The response rate was 63.3% (n=36). The study was cross-sectional in design. Data was collected using a battery of psychometric tests yielding information on distress (The Distress Screener), anxiety and depression (PHQ-9, K10), sleep disturbance (PROMIS scale), alcohol consumption (AUDIT-C), smoking behaviour, adverse nutrition behaviour, career satisfaction (Career Satisfaction Scale) and mental toughness (Mental Toughness Index). *Results:* The prevalence of depression was 14% (n=5). Six percent (n=2) reported suicidal ideation in the last 2 weeks. Fourteen percent met criteria for distress. There were positive correlations between depression and sleep disturbance ( $r=.343, p<.05$ ), between anxiety/depression and distress ( $r=.380, p<.05$ ), and between depression and distress ( $r=.531, p<.01$ ). Career dissatisfaction was identified in 46% of participants and was inversely correlated with mental toughness ( $r=-.485, p<.01$ ). Low mental toughness and adverse alcohol use were identified in 37% and 23% of participants, respectively. *Conclusions:* Elite swimmers experience common mental illnesses and associated psychosocial problems. There is a relationship between career dissatisfaction and low mental toughness. Sport governing bodies should assess their own athlete populations and implement programmes to support mental health.

**Keywords:** mental health, elite swimmers, mental toughness, career satisfaction

## Introduction

The mental health and wellbeing of elite athletes has been recognised as being of utmost importance [1]. The UK government has set the goal of achieving a 'psychologically underpinned environment which enables all to thrive at work' across all elite sporting teams by 2024 [2]. In order to develop a framework and structure to support elite athletes to maximise their mental wellbeing, sporting organisations must understand the extent of mental health problems within their specific sporting populations.

In the past decade, several studies have described a high prevalence of mental health symptoms among elite athletes [3–8]. Gulliver et al. found that 46% of elite Australian athletes experienced at least one mental health problem [8]. Similarly, Gouttebauge et al. found that 45% of current

and former elite Dutch athletes reported clinically significant symptoms of depression [4].

Much of the research into mental health in elite athletes is focussed on sporting populations competing in varying disciplines, yet data from one sport may not be applicable to others [9]. Sabiston et al. demonstrated a positive correlation between the number of years in team sport participation and lower depressive symptoms [10]. However, this positive correlation may not apply to individual sport participation. Swimming is, by its nature, primarily an individual sport. As such swimmers may be at higher risk of developing mental health problems than their team sport counterparts [11].

Despite this, few studies have explored the prevalence of mental health conditions in swimmers. In a study of Canadian swimmers competing to represent their country internationally, Hammond et al. found that the prevalence

of depression in the top 25% most elite swimmers was double that of the overall population of swimmers in the study [12]. A recent study by Mountjoy et al. found that a quarter of 2019 FINA World Championship aquatic athletes were classified as depressed [13].

Common mental illnesses are associated with broadly defined ‘psychosocial problems’, including alcohol misuse, poor nutrition, smoking and sleep disturbance, all of which could be detrimental to a swimmer’s performance [14–16]. To the best of our knowledge, no study has examined the prevalence of these associated problems in swimmers.

The aim of our study was to identify the prevalence of common mental health problems including distress, anxiety, depression and associated psychosocial problems in elite swimmers.

## Methods

### Participants and study design

All members of a national swimming squad were invited to participate in the cross-sectional study. The squad consisted of 55 swimmers, both male and female, ranging in age from 16 to 30. The ratio of males to females in the squad was approximately 50:50. The Chief Medical Officer explained the purpose and format of the study during a routine mental health workshop which all squad members were required to attend. After the event, attendees were emailed a link to an online psychometric test battery. Responses were collected anonymously via online survey with a generic link after informed consent was obtained. No identifiable data on participants was collected. Participants were able to opt-out of the study, and researchers had no way of identifying those who chose not to take part. Data was collected prior to the start of the COVID-19 pandemic, in winter when training is typically high aerobic volume with little competition or racing. Ethical approval was granted by University College London’s Research and Ethics Committee.

The anonymous nature of the responses prevented participants in distress from being identified by the researchers. As such, rigorous mental health reviews were conducted by the Chief Medical Officer in parallel, the outcomes of which are not part of this or any study. The psychometric battery also included practical advice for seeking help in crisis, and details of how to discuss mental health problems with the Chief Medical Officer in confidence.

### Psychometric tests

We used a battery of psychometric tests selected for their validity, use in comparable studies, and ability to detect a range of symptoms and behaviours.

- The Distress Screener (three items on a three-point scale) is based on the Four-Dimensional Symptom Questionnaire [17], [18]. It was used to identify early signs of non-specific distress which are distinct from anxiety and depression. Possible scores range from 0–6, where a score of  $\geq 4$  indicates a threshold for distress met.
- The PHQ-9 (nine items on a four-point scale) is based on the DSM-IV diagnostic criteria for depression and asks about the participant’s experience in the last 2 weeks. Responses range from “0 – not at all” to “3 – nearly every day”. Possible scores range from 0–27, where a score of 8 indicates the threshold for Major Depressive Episode (MDE) is met. In the case that a respondent’s score was  $< 8$  but answered  $\geq 1$  on question 9 (expression of suicide ideation) they automatically met the threshold for MDE.
- The K10 (ten items on a five-point scale) yields global measures of distress based on questions about anxiety and depression. Responses range from “0 – none of the time” to “4 – all of the time”. Possible scores range from 0–40, where a score of  $\geq 20$  indicates the threshold for anxiety/depression is met.
- Sleep disturbance was measured using the Patient Reported Outcomes Measurement Information System (PROMIS) scale. It consists of four items on a five-point scale. Participants are asked to rate their sleep quality according to four statements. Responses range from “0 – not at all” to “4 – very much”. Possible scores range from 0–20, where a score of 13, 16 and 20 indicates mild, moderate or severely disturbed sleep.
- Current alcohol consumption was determined using AUDIT-C (3 items on a five-point scale). Possible scores range from 0–12, where a score of  $\geq 3$  indicates a positive screen for alcohol misuse. Higher scores indicate a greater severity of alcohol misuse.
- To determine smoking behaviour a single question was asked “Do you smoke? Yes/No”.
- Adverse nutrition behaviour was assessed against 4 statements. The intent was to identify unhealthy eating patterns, as opposed to the presence of an eating disorder. Participants were asked to rate each statement from 0–7 indicating how many days of the week their behaviour matched the statement. Possible scores ranged from 0–28, where *consuming healthy meals  $< 5$  days per week, eating regularly throughout the day  $< 3$  days per week, having breakfast before 10:30  $< 3$  days per week and having a final meal before 20:30  $< 3$  days per week* collectively indicates the presence of adverse nutrition behaviour.
- Satisfaction with swimming as a career was assessed using the Career Satisfaction Scale (five items on a five-point scale). Participants rated their satisfaction against statements from “5 – strongly disagree” to “1 – strongly agree”. Possible scores range from 0–25, where scores of  $\geq 10$  indicates career dissatisfaction.

- Mental toughness can be thought of as a psychological reserve, allowing athletes to maintain high performance in the face of stresses which vary in frequency and severity [19]. The Mental Toughness Index is comprised of eight statements relating to mental toughness in sport [20]. It is scored from “0 – strongly disagree” to “4 – strongly agree”. Possible scores range from 0 to 32, where scores of  $\leq 16$  indicate low mental toughness.

## Statistical analysis

Statistical analyses were performed using the Statistical Package for the Social Sciences (SPSS) version 25. Spearman’s rho was used to determine correlations between outcome measures. Statistical significance was set to  $p < .05$  with 95% confidence intervals.

## Results

A link to the psychometric test battery was sent by email to all 55 swimmers in the squad. 36 participants responded to the survey. Thirty-five respondents answered all questions, whilst one declined to participate. The total response rate was 63.3%.

Table 1 summarises the results of the psychometric screening tools. Whilst relatively few swimmers met criteria for depression (14%) and distress (14%), higher proportions reported low mental toughness (37%) and career dissatisfaction (46%).

Correlation coefficients (Spearman’s Rho) between mental health outcomes are shown in Table 2. A weak positive correlation was identified between sleep disturbance and depression ( $r = .343, p < .05$ ), and between anxiety/depression and distress ( $r = .380, p < .05$ ). A moderate positive correlation was identified between depression and distress ( $r = .531, p < .01$ ). A weak negative correlation was identified between mental toughness and career satisfaction ( $r = -.485, p < .01$ ). No other statistically significant correlations were identified between the outcomes measured.

## Discussion

### Anxiety and depression

The prevalence of anxiety and depression in the general population is estimated at 17-18% [21]. The prevalence of anxiety and depression in elite swimmers in this study ranged from 11% for anxiety/depression to 14% for depression. It appears that the elite swimmers in our

**Table 1.** Prevalence of psychological measures

Psychological measure	Frequency	Percent
PHQ-9		
MDE threshold met	5	14.3%
MDE threshold not met	30	85.7%
Suicidal ideation		
Suicidal ideation expressed	2	5.7%
No suicidal ideation	33	94.3%
Distress Screener		
Distress reaching threshold	5	14.3%
Distress not reaching threshold	30	85.7%
Career Satisfaction Scale		
Career dissatisfaction identified	16	45.7%
Career dissatisfaction not identified	19	54.3%
Mental Toughness Index		
Low mental toughness threshold met	13	37.1%
Low mental toughness threshold not met	22	54.3%
K10		
Anxiety/depression threshold met	4	11.4%
Anxiety/depression threshold not met	31	88.6%
Audit-C		
Adverse alcohol use present	8	22.9%
Adverse alcohol use absent	27	77.1%
PROMIS		
Disturbed sleep identified	4	11.4%
Disturbed sleep not identified	31	88.6%
Smoking behaviour		
Smoker	0	0%
Non-smoker	35	100%
Adverse nutrition behaviour		
Adverse nutrition behaviour present	0	0%
Adverse nutrition behaviour absent	35	100%

study had a moderately reduced risk of anxiety and depression compared with the general population.

Other studies examining elite swimmers have found higher rates of depression. Mountjoy et al. reported that 25% of aquatics athletes at the FINA world championships were classified as depressed [13]. A study of Canadian varsity swimmers, 68% met criteria for depression pre-competition, compared with 34% post-competition [12]. Both these studies were conducted in periods of intense competition, suggesting swimmers may be at higher risk of depressive symptoms during peak competition periods.

The prevalence of anxiety/depression in our study was also lower than that found in other elite sports groups. A cross-sectional study of professional footballers a 26% prevalence of anxiety/depression [22], whilst a study of US collegiate athletes found the prevalence of depression was 21% [23]. A study of Australian elite athletes across multiple sports found the prevalence of depression was 27% [8].

**Table 2.** Correlations between mental health outcomes

Variables	Sleep Disturbance	Alcohol Risk	Distress	Career Satisfaction	Anxiety/Depression	Depression
1. Sleep Disturbance	–					
2. Alcohol Risk	–.202	–				
3. Distress	.343*	.028	–			
4. Career Satisfaction	.271	.199	.090	–		
5. Anxiety/Depression	.307	.199	.380*	.083	–	
6. Depression	.335	.341	.531**	.130	.464**	–
7. Mental Toughness	–.222	–.127	–.274	–.485**	–.324	–.256

Notes. \*Correlation is significant at the 0.05 level (2-tailed). \*\*Correlation is significant at the 0.01 level (2-tailed).

Pluhar et al., in a cross-sectional study of child and adolescent athletes participating in a range of sports, concluded that individuals participating in team sports had lower rates of depression and anxiety than those in individual sports, but that both had lower rates than the general population [11]. However, it is not clear that these conclusions would apply to elite sporting populations. In their narrative systematic review, Rice et al. emphasised the need for further high quality research into the mental health of elite athletes [9].

## Alcohol behaviours

In our study, 23% of swimmers screened positive for alcohol misuse. Thirty two per cent of men and 26% of women between the ages of 16 and 24 in England drink at increasing and higher risk levels [21]. Despite heavy drinking rates lower than the age-matched general population, levels of alcohol misuse remain surprisingly high given the competitive environment of the sport, where small margins can mean the difference between winning and losing. One may assume that swimmers would be cautious not to engage in activities which may affect their performance. Higher than average rates of alcohol use have been found in other elite sporting populations [24, 25], where the increased prevalence has been attributed to bingeing outside of competition periods [9]. The harmful effects of binge-drinking are well documented [26], and sports organisations with high levels of alcohol misuse may focus interventions in this area.

## Suicidal ideation

Suicide has been highlighted as a specific concern amongst elite sporting populations [27]. The prevalence of suicidal ideation in our study (6%) was similar to that found in a study of Japanese top league rugby players, but was much higher than that found in a large study of French athletes [28, 29]. These differences are likely explained by the small sample size in our study. Nevertheless, it remains a cause

for concern as suicide is the most common cause of death for men and women in the UK between the ages of 10 and 34 and all participants in this study fall between these age ranges [30]. We were not able to identify those participants reporting suicidal ideation, as the protocol and ethical approval for this study required responses to be anonymised, however rigorous mental health screening was undertaken by the Chief Medical Officer in parallel to identify those with concerns.

## Smoking and adverse nutrition

No participant in our study reported smoking or adverse nutrition behaviour. This is unsurprising considering either would likely be incompatible with elite performance and recovery. It should be noted that elite athletes appear to suffer eating disorders at higher rates than general populations [31], however our study aimed to identify patterns of unhealthy eating as opposed to clinical eating disorders.

## Career satisfaction and mental toughness

A high prevalence of career dissatisfaction was identified amongst the elite swimmers in our study (46%). This finding is concerning given Foskett et al. identified career dissatisfaction as a risk factor for developing mental illness in elite athletes [32]. In our study we found no correlation between career satisfaction and anxiety/depression. We did however identify a negative correlation between career satisfaction and mental toughness ( $r=-.485$ ,  $p<.01$ ), suggesting those who are poorly satisfied with their career may be less well equipped to manage the inherent stresses involved with elite athleticism. Preventative interventions against the future development of mental illness in elite athletes may focus on improving individuals' satisfaction with their chosen career, or their psychological resilience (mental toughness) to the inherent stresses of the sport. It is, however, important to note that this is unlikely a panacea, and that mental toughness alone does



not equate to resilience to a multifactorial disease such as depression [33].

## Limitations

The main limitation of this study was that it was conducted on a single squad at a single timepoint. The results presented should be interpreted with caution given the small study population. Future work could focus on tracking mental health symptoms over time and in response to specific psychological interventions. Furthermore, the response rate of this study was less than 100%, and as such there may have been selection bias in respondents.

Ethical approval was obtained on the basis of anonymity and an inability to collect person-identifiable data. Whilst it may be expected that anonymous evaluation enabled more candid answer behaviour, the confines of the ethics approval limited our ability to comment on the impact of age or gender on the prevalence of common mental health problems. In addition, it prevented participants scoring highly on measures of mental ill-health to be identified. Rigorous parallel mental health evaluation was undertaken alongside this study to identify swimmers who were struggling.

## Conclusions

This study has shown that elite swimmers suffer with anxiety, depression, and alcohol misuse, though at rates lower than the general population and many other swimming and non-swimming sports organisations. Further research into how these problems vary over time would help clarify where resources to improve mental health should be focussed. Suicidal ideation at any level is of major concern, and efforts should be focussed towards managing acute psychiatric risk in elite sporting cohorts. Sports organisations should assess their own populations and implement robust clinical assessment and treatment programmes for their athletes.

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# Sports psychiatry clinical curriculum for sports and exercise medicine fellows in one Canadian university

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**Abstract:** *Introduction:* Athletes can experience the same mental illnesses as the general population. Sports create additional circumstances that can influence the mental health of its participants. Sport and Exercise Medicine (SEM) physicians are often on the front lines of providing medical assessment and treatment to athletes for a variety of presenting complaints. Enhancing the knowledge base and clinical approach of Sport and Exercise Medicine physicians for assessment and management of mental health challenges in athletes can assist in early identification, assessment, treatment initiation, or referral to a sports psychiatrist. Providing SEM trainees with formal clinical exposure to Sports Psychiatry can better equip them for their future practice. This article describes a formalized clinical rotation in Sports Psychiatry for SEM Fellows in one Canadian university. *Methods:* In collaboration with the SEM Fellowship program, a formal Sports Psychiatry rotation was created to ensure every Fellow had exposure to mental health assessment and management of athletes appropriate to what would be expected of SEM physicians. *Results:* A four-week curriculum which included direct clinical assessment, treatment initiation, follow up, and presentation of case-based mental health topics appropriate for SEM physicians. This program was reviewed during accreditation as part of the Enhanced Skills curriculum of the postgraduate Family Medicine program at McMaster University in 2023. *Conclusion:* An integrated Sports Psychiatry rotation during a SEM Fellowship provides an opportunity for future SEM physicians to have exposure to a clinical population of athletes with mental health concerns to develop tools for assessment, management, and collaborative care.

**Keywords:** psychiatry, sports, training, sports medicine, curriculum

## Background

Sport and Exercise Medicine (SEM) physicians are integral to the assessment and management of the overall health and wellbeing of active individuals. The scope of practice of an SEM physician spans knowledge and expertise in the importance of exercise in general population health [1] as well as assessment and management of athlete-specific health. The range of athlete-specific health concerns include physical medicine and psychological challenges. Physical challenges such as injuries, illnesses, eating disorders and traumatic brain injuries (TBIs) can influence athlete mental health [2, 3], and psychological struggles can predispose athletes to injuries, illnesses and performance struggles [2, 3]. Accurate reporting on the prevalence of mental disorders and challenges in athletes has proven challenging due to inconsistencies in the use of study instruments, lack of reference groups with the general population, lack of attendance to cultural elements, and lack of clarity with respect to use of objective versus

subjective diagnostic measures. The available data reports prevalence rates of up to 45% for depression and anxiety in male elite athletes in select team sports, and between 10% and 25% for the prevalence of eating disorders and depression among collegiate athletes [3].

One study that explored the tendency for SEM physicians to address specific psychological elements with athletes identified that SEM physicians frequently encountered psychological symptoms with athletes, and that SEM physicians would benefit from greater awareness of mental health resources available to athletes [4]. A key joint consensus statement published in 2016 identified the importance of the team physician's role in recognizing athletes at risk of psychological struggles and providing referrals for additional care when appropriate [2].

Practice models of SEM physicians in Canada include part time practices dedicated to athlete care balanced with additional hospital-based or office-based practices in Family Medicine, Emergency Medicine, Orthopedic Surgery, Pediatrics, or Physical Medicine and Rehabilitation

(Physiatry). Family Medicine residency program requirements are governed by the College of Family Physicians of Canada (CFPC), while specialty training programs are governed by the Royal College of Physicians and Surgeons of Canada (RCPSC). SEM Fellowship programs in Canada span twelve months (featuring twelve one-month rotations) which offer their candidates a focused and comprehensive educational year to prepare them for a career that includes SEM as part of their practice [5]. The Fellowship consists of one year of clinical exposure and scholarly activities that follows the completion of a two-year Family Medicine residency program. After completion of the Fellowship, trainees qualify to be awarded the Certificate of Added Competence (CAC) by the CFPC [6]. Residents from specialty programs (such as Physiatry, Emergency Medicine and Pediatrics) have to ability to embed the SEM curriculum within their programs through electives. Since the SEM Fellowship is not accredited through the RCPSC, trainees from specialty programs do not qualify for a Diploma of Focused Competence through that professional body. The SEM Fellowship program prepares all trainees to sit the Diploma in Sports Medicine examination with the Canadian Academy of Sport and Exercise Medicine (CASEM), which provides additional internationally-recognized certification for a Sports Medicine practice [7].

Sports Psychiatry is a defined medical field that features additional focused training and specialized application of psychiatric practice to the assessment and treatment of athletes [8, 9]. The specific knowledge, skills and abilities of a Sports Psychiatrist are developed over many years of specialized training, clinical exposure, and continuing professional development [10]. Sports Psychiatrists complete comprehensive biopsychosocial formulations that include unique sport and athlete characteristics to understand the elements contributing to the athlete's challenges. Background medical and psychiatric training facilitates scoping evaluation of medical and psychological dimensions, allowing for understanding of complex challenges that can present in athletes as well as sport-related considerations for treatment [11]. To enhance the knowledge base and clinical approach of Sports Psychiatrists, the International Society for Sports Psychiatry (ISSP) developed the ISSP Portable Didactic Curriculum [12] and certificate program [13]. Candidates who successfully complete the certificate program are awarded the Certificate of Additional Training in Sports Psychiatry.

Sports Psychiatrists and SEM Physicians can work together as members of an integrated support team (IST) or multidisciplinary team (MDT) or may collaborate externally for athlete care if not directly related within the same organization. Collaborative care between SEM physicians and Sports Psychiatrists can optimize the mental health

assessment and management of athletes with mental health challenges and mental illnesses. Such collaboration can also develop safe return to sport plans for athletes whose sport participation has been interrupted or influenced by mental illness.

Ideally, athletes – particularly those on competitive, high performance, elite, and professional pathways – should have access to comprehensive support that spans medical (including physical and psychiatric medicine), sports science and allied health/paramedical supports. In 2019 the International Olympic Committee Mental Health Working Group (IOC MHWG) released the IOC Consensus Statement Mental Health in Elite Athletes, which identified the importance of a comprehensive, athlete-centered integrative assessment approach [3]. It is important for all personnel who interact with athletes to have an awareness of indicators of mental health challenges. In 2020 the IOC MHWG developed the Sport Mental Health Assessment Tool 1 (SMHAT-1) to facilitate mental health screening of elite athletes older than 16 years of age by sports medicine physicians and/or licensed mental health professionals [14]. The Sport Mental Health Recognition Tool (SMHRT-1) was developed for use by the athlete and/or members of their entourage to recognize signs and symptoms of mental health challenges [14].

SEM physicians have an important role in initial identification and management of psychological symptoms. Enhancing the knowledge base and clinical approach of SEM physicians for assessment and management of mental health challenges in athletes can assist in early identification, assessment, treatment initiation, or referral to a sports psychiatrist. Specialized expertise provided by sports psychiatrists should be engaged for chronic, complex, or severe cases of mental illness, delivery of psychotherapy and pharmacotherapy, and overall case collaboration.

This paper describes the creation of an integrated Sports Psychiatry rotation within an SEM Fellowship for the purpose of enhancing the knowledge base and clinical approach of future SEM physicians in assessing and treating athletes with psychological challenges.

## Methods

The integration of Sports Psychiatry as a permanent rotation for SEM Fellows required programmatic review, interdepartmental collaboration, and demonstration of the anticipated value of the rotation. Program design followed. Programmatic review included examination of the curricular components, evaluation methods, and discussion with the Program Director. Interdepartmental collaboration included discussion with clinical and academic



preceptors involved in the delivery of the Fellowship rotations, and demonstration of the anticipated value was identified through on a literature review of the role of SEM physicians in assessing and managing psychological challenges in athletes.

## Program review

The PGY-3 SEM program at McMaster University provides a comprehensive educational and clinical year of training that prepares individuals for a career that can feature SEM as part of their practice [5]. The SEM program is competence-based and offers a broad scope of educational experiences with a primary focus on SEM clinics, field and event coverage opportunities, elective opportunities in disciplines related to SEM, support for research and scholarly pursuits, teaching, and skills development in educational presentations. The fellowship year is delivered through twelve one-month rotations, including ten months in primary care sports medicine in an approved Sports Medicine clinic, one month in an orthopedic surgery setting, and one month in Sports Psychiatry. The program accepts one to two Fellows per year. The goals and objectives of the SEM training program are aligned with the College of Family Physicians of Canada (CFPC) Priority Topics and Key Features for assessment of competence in SEM [6]. Performance on all rotations are evaluated using an In-Training Evaluation Report (ITER) that is approved by the university's postgraduate curriculum committee, which is illustrated in Electronic Supplementary Materials (ESM) 1.

## Interdepartmental collaboration

In planning the curriculum for the subsequent year, all clinical teachers and supervisors were engaged in a discussion around rotation locations, target athlete populations, clinical exposures, and overall goals.

## Literature review

Relevant articles were identified through searches of PubMed, Google Scholar, and online exploration of SEM programming in Canada and the United Kingdom. Search criteria included the terms "sports medicine training", "sports and exercise medicine training," "sports and exercise medicine fellowships," "sports psychiatry AND sports medicine," "integrated sports psychiatry training," "sports psychiatry curriculum," "athlete mental health," "sports mental health," and "sports psychiatry." Articles that identified the role of the SEM physicians in treating athletes with mental health concerns, key mental health topics in

athletes, and approaches to screening and management were reviewed to guide rotation goals and objectives.

## Program design

Prior to the formal integration of a Sports Psychiatry rotation into the McMaster University SEM Fellowship program, SEM Fellows spent approximately 7 days during clinical placements with a Sports Psychiatrist who was embedded in a Sports Medicine clinic. These exposures were informally organized and not guided by specific goals and objectives.

The Sports Psychiatry clinical experience involves assessment and management of athletes of all ages and competitive levels, spanning youth athletes to collegiate, elite, and professional ranks. Clinical and learning objectives guide teaching and exposures. Rotation objectives are presented in Table 1.

While the clinical Fellows are exposed to athletes with a wide spectrum of severity of mental health challenges through the rotation, cases are carefully selected for initial assessment and management that are appropriate to the competencies that would be expected of an SEM physician in addressing athlete mental health as a primary care provider. Prior to the beginning of the rotation, SEM Fellows are advised to review the ISSP Portable Didactic Curriculum for foundational knowledge development [curriculum]. The general approach to the Sports Psychiatry rotation each week is as follows:

### Week one

During orientation on the first day of the rotation, a general overview of important topics (which are aligned with the ISSP Curriculum) is reviewed. During the first week of the rotation, the SEM fellow first observes several comprehensive Sports Psychiatry assessments to understand the unique sport- and athlete- specific elements that should be incorporated in the interview. The key elements that should be included in the mental health clinical interview for diagnostic assessment of an athlete are Listed in Table 2.

Discussion occurs around each case to review clear and nuanced elements of mental health as it applies to the individual, team and relationships. New assessments performed by the SEM Fellows are observed by the Sports Psychiatry supervisor and feedback is provided. Teaching also occurs around more chronic cases that feature complex pharmacotherapy, psychotherapy, and safety concerns. Safety assessments are performed on all patients, and mental health legislation is applied as appropriate. The complex interplay of sports and mental health is discussed in the context of each athlete's experience (which can be unidirectional or bidirectional). Management and follow up plans are discussed and established.

**Table 1.** Clinical goals and objectives for sports psychiatry experience for SEM fellows**Sport and exercise medicine fellow sports psychiatry clinical experience – Goals and objectives**

## Setting

Outpatient Sports Psychiatry clinical locations (can include sports venues, sports medicine clinic, private sports psychiatry clinic, virtual care [Zoom platform])

## Goals

1. Become familiar with common presenting mental health challenges in athletes.
2. Recognize thresholds for management of mental health challenge within a sports medicine practice and involvement of Psychiatry.
3. Become familiar with psychiatric medication consideration for athletes.
4. Understand and address elements of safety and risk with athletes.
5. Recognize and explore maltreatment.

## Objectives

1. Conduct a complete mental health assessment of an athlete, with additional consideration of sport-specific factors.
2. Identify sport-related elements that can influence an athlete's mental health.
3. Identify mental health elements that can influence sport performance.
4. Describe obstacles athletes face in obtaining support for mental health challenges.
5. Recognize common factors that may indicate athlete maltreatment (abuse, harassment, neglect, involving psychological, physical, and sexual dimensions).
6. Understand limitations and mechanisms for reporting maltreatment in sports.
7. Describe the approach to choosing and managing psychopharmacology in athletes.
8. Complete a risk assessment of an athlete.
9. Identify key components that should be considered when clearing an athlete to return to play following an episode of mental illness.
10. Describe key considerations when determining an athlete's fitness to travel for training and competition.

**Table 2.** Key elements that should be included in the clinical mental health interview for diagnostic assessment of an athlete**Recommended components of the mental health assessment of athletes**

1. *Identification:* including name, age, living situation (type of residence, who they live with)
2. *Primary complaint/reason for referral*
3. *History of presenting illness:* including primary symptom cluster, associated symptoms, exploration of diagnostic criteria, current comorbidities
4. *Sport history:* including influence of sport on mental health challenges or vice versa. Explore current sport, support system, primary care providers, history of maltreatment, dynamic in sport environment, response to sport-related adversity
5. *Screening:* explore previous/recurrent/comorbid psychiatric diagnoses
6. *Past psychiatric history:* including previous diagnoses, hospitalizations, self harm, suicide attempts, previous assessments or therapeutic relationships with mental health professionals
7. *Past medical history:* including thyroid disease, traumatic brain injury, iron deficiency, low energy availability, vitamin B12 deficiency, sleep apnea, previous surgeries
8. *Medications:* including past medications, optimization of trials, adherence, adverse effects; present prescribed and over the counter medications, adherence, and response; herbal supplements, vitamins, minerals, workout supplements, homeopathic preparations
9. *Allergies and adverse reactions to medications or substances*
10. *Substance use:* including caffeine, alcohol, cannabis, unprescribed medications, stimulants, illicit drugs, performance enhancing drugs (including anabolic steroids)
11. *Family psychiatric history:* including mood, anxiety, or psychotic disorders, psychiatric hospitalizations, suicide, violence, ADHD, learning disorders, substance misuse, and undiagnosed (but suspected) psychiatric illness
12. *Social history:* Including cultural elements, relationship development, academic and employment history, family sport history, influence of family on sport experience and identity.
13. *Forensic history:* including history of involvement with the legal system, incarceration, aggression, and anger management difficulties
14. *Mental status examination:* including descriptions of appearance, eye contact, speech patterns, orientation to person, place and time, thought content and formation, mood (subjective), affect (objective, including range and congruence with behavior and content being discussed), intellectual resources, insight, judgement, suicidal and homicidal ideation.

General topics covered in teaching sessions and clinical case exposures include:

- athlete maltreatment
- common mental health presentations in athletes (including mood disorders, anxiety disorders, trauma, attention deficit hyperactivity disorder (ADHD), sleep disorders, substance abuse, personality disorders, traumatic brain injuries, eating disorders, and sequelae of relative energy deficiency in sports)
- considerations for pharmacotherapy in athletes
- understanding and addressing elements of safety and risk with athletes
- recognizing thresholds for management of mental health challenges within a sports medicine practice and referral to Sports Psychiatry.

### Weeks two and three

The SEM Fellow carries a caseload of athletes who were assessed during previous weeks and performs 2–3 new independent assessments and treatment initiations per week. Treatment initiation includes psychoeducation, instruction of coping skills (such as breathing skills, relaxation, and grounding) and/or pharmacotherapy for mental health conditions as indicated. Pharmacotherapy may include antidepressants, antipsychotic agents, anxiolytics, sedative/hypnotics, or treatment targeting ADHD. Fellows are also involved with the preparation of Applications for Therapeutic Use Exemptions as needed. Supervision is provided through observation and case review, and verbal feedback is provided daily.

### Week four

The SEM Fellow continues to carry their caseload of athletes who were assessed and started on management plans during the first three weeks of the rotation. They perform 2–3 additional new independent assessments and treatment initiations (as previously described). As they approach the end of the rotation, they review the progress of the athletes on their caseload and engage in long term planning for ongoing mental health support. A rounds-style presentation is then developed based on cases seen during the rotation and presented to the local SEM teaching group.

Evaluations are submitted as per university policy in the form of an in-training evaluation report (ITER).

## Results

Following curricular review and collaboration with the SEM Program at McMaster University, a dedicated Sports Psychiatry rotation was developed and integrated into the Fellowship program. Goals and Objectives were developed

to guide clinical and academic exposures, and supplemental educational material was incorporated from an established ISSP Sports Psychiatry curriculum. SEM Fellows were exposed to key topics in athlete mental health that were intended to enhance their knowledge base and approach to clinical management of athletes with mental health concerns. The structure of the rotation facilitated clinical teaching, observation, a guided approach to pharmacotherapy in athletes, and daily supervision. Verbal feedback obtained from the athletes was incorporated with objective clinical evaluation to guide the final evaluation report. This rotation will be delivered to 1–2 SEM Fellows per year.

## Discussion

Athlete health and wellness spans both physical and mental health dimensions. SEM physicians interact with athletes for many reasons, including pre-participation screening, assessment and management of injuries and illnesses, concussion management, and return to sport planning. The ability to detect and manage mental health challenges in athletes adds important assets to the SEM's clinical arsenal. Specialized training in athlete mental health with a Sports Psychiatrist provides the SEM Fellow with exposure to a clinical population with which to learn specific mental health assessment tools, engage in initial clinical management, and collaborate with Sports Psychiatry colleagues. Long term goals of an integrated training program involving SEM and Sports Psychiatry include earlier identification of mental health challenges in athletes and more rapid initiation of management plans and referral for specialized care. Outcomes of enhanced detection may eventually include higher reported rates of mental health challenges in athletes, although that remains to be seen. A desired outcome of increased competence in mental health assessment and treatment by SEM physicians would be earlier and more widespread access to treatment for athletes who would benefit from treatment for mental health challenges.

## Limitations and future direction

One limitation of this report at this time is the relative infancy of the program (1 year), which prohibits the reporting of significant outcomes beyond the execution of the program and the performance of the Fellow (who successfully passed the rotation). In addition, the author of this paper is also the Sports Psychiatrist involved in the development and implementation of the program. The intention was to describe the program in an objective fashion to demonstrate the intended utility; however, it must be

identified that any perceived interpretation of results may be influenced by the author's involvement with the program.

For continuous quality improvement, it will be beneficial to develop assessment instruments to measure changes in the domains of knowledge base, clinical assessment, and management pre-and post-rotation.

## Conclusion

An integrated Sports Psychiatry rotation during a SEM Fellowship provides an opportunity for future SEM physicians to have exposure to a clinical population of athletes with mental health concerns to develop tools for assessment, management, and collaborative care. This program serves as a template for Sports Psychiatry rotations to be integrated into Sports Medicine training programs where resources are available. Assessing program effectiveness with pre- and post-rotation measures can guide program improvement.

## Electronic Supplementary Materials (ESM)

The electronic supplementary material is available with the online version of the article at <https://doi.org/10.1024/2674-0052/a000054>

**ESM 1.** In-Training Evaluation Report (ITER) used to evaluate trainee performance following each rotation.

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# A sports medicine update to American basketball

Contributions and changes from abroad and implications for sports medicine and psychiatry

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This article updates our previous papers on psychiatric aspects of basketball, which had the aim of providing diagnostic and treatment implications for physicians doing Sports Medicine and Sports Psychiatry. Using articles from the sports media and from clinical experience, we update that broad overview from the European perspective. That is focusing on those athletes born in Europe or who have arrived in the U.S. born in Africa via Europe, who have in important and new ways changed the American game. As such, this is the first paper that details the European perspective for athletes, athletic teams, leagues, countries, and the sport itself. These athletes have changed the nature i.e. style, psychology, and medical-psychiatric aspects of this American game – changes which Sports Psychiatrists need to be aware of to improve treatment efficacy.

In 1989, one of us (IDG) wrote the first paper on “psychiatric aspects of basketball” with the aim of providing diagnostic and treatment implications for physicians doing Sports Medicine and Sports Psychiatry [1]. In that paper, we described “mental health,” physical health, and the psychiatric aspects of the game in three related areas/issues: 1) individual, 2) team, 3) community and country. We wrote:

“Basketball is enjoying wide popularity and growth today for a variety of reasons – not the least of which are the facts that it fulfills individual and family needs and helps to bridge the gap between individuals of different countries and different races. It is a sport that requires the combination of skill, strength, intelligence, and mental health in a unique, challenging and creative way.

When basketball ‘goes right,’ it can do much to develop psychological awareness of others, physical skills, and the ability to think quickly and decisively.

It can also go wrong – not only for an individual player and/or their team, but also for the community/country at large – when players are improperly used for the sports organization’s own ends” [1].

Our objective in that paper was to lay out the symptoms, problems, illnesses that athletes present for diagnosis, treatment and long-term management. It was aimed not only for physicians – but also for the trainers working closely with the athletes. Somewhat surprisingly, it was used by coaches, administrative staff, agents, and basketball leagues, including the National Basketball Association (NBA) and Women’s National Basketball Association (WNBA). In part, based on the feedback we received, we updated this paper in 2018 [2], focusing on the then new “mental health” services available – with a focus on issues, problems, and psychiatric disorders like substance use disorders, personality disorders as well as diseases with a genetic etiology like anxiety and depressive disorders, attention deficit disorder and schizophrenia.

Subsequently, we searched the literature. To the best of our knowledge, we were unable to find articles discussing how the American game has changed secondary to what European players brought to America. We have found papers, which in a more general way describe diagnosis and treatment of athletes globally playing a variety of sports [3, 4].

In this article written for those practicing Sports Medicine – we update that broad overview, with a focus emanating on, and from the European perspective. We try to make clear that European players have changed the psychology, psychiatric aspects of the sport to make what we believe increases the complexities of the mental game in the context of the physical, raw athletic play of the American game. We focus on those athletes born in Europe or who have



arrived in the U.S. born in Africa that grew up and/or played in Europe and then came to the U.S., via Europe, who have in important and new ways changed the American game. As such, this is the first paper that details the European perspective for athletes, athletic teams, leagues, countries, and the sport itself. By way of example, last season (2022), Nikola Jokic won his second successive NBA Most Valuable Player (MVP). Furthermore, for that award there were other, very close and worthy choices including Luka Doncic, Joel Embiid and Giannis Antetokounmpo – all of whom have changed the nature i.e. style, psychology, and medical aspects of this American game. In short, players like these have changed the psychology of the game, resulting in changes to both the physical as well as the mental health of athletes.

## Background

As some sports lovers say: “B-Ball is life,” and as *Life* it continues to grow and evolve. We have made giant footsteps as a sporting civilization since James Naismith created basketball. At that time back in 1891, it was viewed as a way of spending time. Still, nowadays, it is viewed almost as a “revolution in major sports competition” having great global popularity roughly equal to football/soccer. Simultaneously, focusing on the NBA, we see that the number of foreign players continues to grow. Starting the 2022 season, 109 foreign-born players were under contract with NBA franchises (approximately 25% of all players) [5]. We now see flashy and spectacular plays that fans love, even from the European players, who were once considered “wooden-legged, silk-hands, skinny, white people.”

Well before 1989, the contacts between Europe, especially Eastern Europe, were almost nonexistent. As it happened, the Eastern part of Europe was the area with one with the largest basketball cultures globally, excluding the United States. From the early years at the Melbourne Olympics in 1956 to the Seoul Olympics in 1988, we observed several forces collide in the world of basketball: first, in the United States with their Team USA Basketball, and second being the Yugoslavian national basketball team and national teams from the Soviet Union. These teams, and how they played, created a new European basketball culture based on the Eastern European states as the model. In short, it was a different way of thinking and strategizing. At the same time, Team USA developed the culture of what some understood as a more athletic and a more individually focused team, starting from the earliest Olympics. The toughest encounters were games with these two above colossi competing against each other.

From the US point of view, European players were viewed as anything but “athletic athletes.” Likewise, there was a

different point of view in Europe that still flourishes among older observers as, “just business, they want to *entertain* “athletically” to sell a product to some fans. That’s not basketball, that’s some sort of a circus.”

## Changes in American basketball via Europe and Africa

How did things change? In a companion paper, now under review in a sports magazine online, we have described in detail the origins and history of European basketball – the athletes who made or did not make American teams, their early development and training as kids, the conferences, countries, teams and leagues in which they played, and most important, how they changed the American game [8]. There is an old saying, “There is nothing so constant as change.” From that paper, we summarize some of these changes – acknowledging that these are broad, generalizations, yet for the medical objectives of this paper, they provide a grounding for the sports physician to understand and prescribe interventions in the context of both the psychology and the physical aspects of their European countries.

Previous articles have delineated 1) how American basketball has changed, 2) how athletes – both men and women – are more diverse and think/play differently and 3) some of the diagnostic and treatment issues are now different and require a different approach [6, 7].

Here we summarize with the following generalizations (and of course there are exceptions to generalizations):

- European players are more focused on *learning individual fundamentals*, and a bit less on “athleticism.”
- European training systems are more *egalitarian*, focused on *the team rather than the individual* from the players from four decades ago.
- Foreign “big men” have improved their shooting skills and their footwork *for both self-creating and creating for others* on the perimeter, rather than mostly playing with what has been described as brute strength in the post.
- European players are more focused on *controlling the “rhythm and tempo”* “slowing things down,” compared to others who have developed skills at *speedily moving aggressively and athletically to the basket*.
- Europeans are known for being *tough defenders*, all in the context and facilitated by European rules, which allow more physical contact. Even so, they are still seen by some as less capable of individual defense than US players.

Other players, coaches or sports writers may have contrary views. There is very little data or expert sources to rely on.

The point here is that European players have created changes in American basketball. As such, these changes have had significant effects on the “psyches” of most players. Sports psychiatrists need to be aware of changes such as these and of rule changes.

## Implications for the sports physician

Given the above, modest changes in the game, the work continues to be – how best to help the athlete play and stay healthy before, during and post career. First, it is crucial to understand the changes that have occurred in the American game and what this means for the athlete and their teams. Then integrate your understanding of them into medical-psychiatric practice. Second, note that “depression and anxiety” are often what are called “presenting symptoms”: Actually, what athletes mean when they say they are depressed or anxious is that they are asking for help to deal with A) team issues (“They don’t throw me the ball or don’t like me”), B) problems (“I don’t get enough playing time or I’m not being paid enough”), C) illnesses like Diagnostic and Statistical Manual V (DSM) anxiety or depressive disorders as well as D) life issues, i.e. being a rookie or facing or having troubles in retirement [8]. Worse still are prejudices or biases – “I’m Russian, but my teammates blame me for the war.” These issues have to be understood, diagnosed and managed by physicians and by therapists, working with brain-mind issues.

This involves both practicing quality psychopharmacology as well as integrating individual, family and group psychotherapy into treatment, depending on the diagnosis and situation. Therapy sometimes has to be provided by physicians familiar with the player’s culture. Athletes commonly have preferences or biases about the physician or therapist being of the same age, gender, or race – although there is no solid scientific evidence that these factors importantly affect treatment outcome [6]. Having said that, the sports physician should be aware that cultural factors to varying degrees may affect outcome [6].

In summary, the sports physician needs to be able to, and competent to, provide evidence-based interventions for the medical and psychiatric disorders/illnesses they manage – e.g. antidepressants for major depressive disorder, antipsychotics for psychosis, etc and know how to integrate the different types of psychotherapy with medication. Given the changes we describe, A) the more physical the play, the more orthopedic problems may result and B) the more rapidly the interactions with teammates, the more challenging it may be psychologically, i.e. creating anxiety for some players. That might lead to cognitive difficulties like dysfunctional anxiety or disorders like GAD or dysthymia [4, 6, 8, 9].

## Conclusion

From our perspective and opinion, American basketball has changed and is on the right path to develop and build a strong combined and integrated culture of European, African, and American style of play. It is based in part on changing past negative attitudes about European players as well as integrating positive changes. We note continual development of thoughtful play and a “feel” for the game, which *can’t* be taught, but can be learned at a young age. European basketball is more open at this time to send young players overseas. With the globalization and the spread of information made possible by social media, watching the NBA on a daily basis becomes possible and challenging to existing styles and current play. European players coming back from America and playing with their national teams now show an increase of skills. All this has given birth to a new way of team-play both in its technical and physical aspects. As such, structurally we see the birth and development to stardom of players like Giannis, Doncic, Embiid, Kristaps Porzingis and others, perhaps best illustrated, like the 19 year old, French prospect Victor Wembanyama – the probable next first pick in the NBA Draft and one of the most highly hyped prospects of all time.

We believe the bottom line for the sports physician – basketball competition has changed from “winning at any cost” to competing to win, but working together to improve life for the athlete, leagues, tribes, communities, cities and countries that the teams represent. We’re all in this together to advance civilization. And it’s up to us across continents to work together as well as for the sports physician to provide the crucial medical and psychiatric help to achieve these new goals.

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# Getting “a head” of the game – Cricket and brain injury

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## Introduction

Concussion or sports related traumatic brain injury in elite level cricketers occurs relatively infrequently when compared to injury of other areas of the body [1]. Despite this, high profile incidents of cricketers attempting to “play through” a brain injury as well as retiring from the professional game as a result of persisting neuropsychiatric symptoms have been highlighted by the media [2, 3, 4, 5]. Given the less predictable nature and variable course of traumatic brain injury, prompt and comprehensive assessment by informed medical practitioners has come into greater focus. Cricketing authorities within the UK and Australia continue to prioritise the topic and provide information by way of modules and infographics to support players, coaches and medical personnel in order to manage acutely and minimise the risk of adverse longer term outcomes [6, 7, 8]. Thus, we consider significant recent publications and highlight some of the wider issues involving brain injury in cricketers.

## Performance related measures

O’Halloran et al. present a useful performance analysis of elite level cricketers (batting and bowling averages) following a helmet/head strike [9]. Most notably, there was a significant decline in performance measures at 3 months in the study group not diagnosed with a concussive injury following impact. Added to this, the analysis gives further credence of difficulties faced in identification of behaviours suggestive of a brain injury by observation alone.

Performance related data have not been typically measured when considering sport related brain injury. Rather, the scientific community has tended to focus on data related to various methods of neuropsychological testing in order to describe symptomology and assess progress

through return to play strategies. Focus on performance related factors is welcomed. It will contribute to a wider understanding and acceptance of sports related traumatic brain injury, particularly so from a players or coaching perspective.

## Lower levels of cricket

Within the amateur game there is no recognised brain injury protocol that can be used by non-trained professionals. Thus players, umpires, coaches, family/friends and spectators should exercise caution with letting a batter continue their innings (or training) following head impact. A knowledge of first aid, potential “red flags” and onward basic self-care should be widespread and influence decision making in the minutes, hours, days and weeks following. This requires wide dissemination of information from cricketing authorities as well as a change of culture and approach towards batters who have been “hit”. Added to this, cognisance of cricket related brain injury not being an injury solely of batters being hit on the helmet should be considered – mechanisms of injury involving wicketkeeping and fielders exist, for example colliding with each other or head contact with the ground or advertisement boards on the boundary edge [10].

## Elite level cricket

In elite level cricket where there is greater availability to medical professionals, the recognition and management of brain injury continues to be a challenge. At present, there is no biomarker for brain injury and limitations of immediate or “on-field” examination exist. With livelihoods at stake, batters may want to play on following any impact and thus want to “beat” or hide symptoms from those

examining them. Insight into compromise of performance and long term sequela following brain injury may not be considered when in the middle of intense competition.

There can be variation between sports as to how the topic of brain injury is approached and managed, despite apparent multisport consensus [11]. As noted above [9], use of video is increasingly being considered as a way of aiding decision making in cricket, albeit with limitations. Descriptions of how various neurological symptomology may present following head impact have been attempted but agreed definitions have not been made thus far [12]. Furthermore, previous work within cricketing populations has suggested atypical presentation following impact [13]. To further complicate, symptoms and signs from brain injury can evolve and present sub-acute, which require evaluation at, as yet unspecified time periods. Data from the elite level game, including that of elite female cricketers, suggest up to 70% of diagnosed “concussions” can have a “delayed” presentation [10]. Self-report questionnaires are still relied upon within some of the main assessment tools [11, 14].

## Law changes

At Test Match level there has been introduction of concussion replacements in order for teams not to be penalised for withdrawing a player suffering from or suspected as having a “concussion”. This removes pressure on medical staff to make decisions quickly and likely lessens the likelihood of errors being made. The main cricketing administrations provide guidance and support for practitioners working within the field [8, 15, 16]. The Sports Concussion Assessment Tool Version 5 [11] cannot be carried out in less than 10 minutes and if carried out as recommended, could last up to 20 minutes in an optimal environment, allowing time for resolution of increased heart rate and “decompression” from the heat of competition.

Mandatory changing of a helmet following impact is now routine practice within the highest level of cricket. The purpose of this change of equipment should be made clear and not overlooked – in that the helmet is not necessarily protective of further brain injury. Furthermore, there is potential for increased risk of harm if helmet replacement is perceived by a batter to be part of a primary or secondary prevention strategy or indeed if symptoms have not become noticeable at the time of original assessment.

## Mental illness in cricket

Mental health symptomology has been associated with head injury in other sports [17]. Longer term, there has been stark neurocognitive outcomes in ex-professional soccer

players [18]. A smaller study but with similar methodology, of ex professional cricketers highlighted the lower rate of many chronic health conditions when compared to that of a matched general population [19]. None of the sample of 113 individuals reported a dementia syndrome. Somewhat surprisingly then, in this cohort of cricketers with better general physical health outcomes, anxiety and depression as diagnosed by a family physician was noted to have higher standardised mortality ratio when matched to the general population.

Disturbed sleep and anxiety/depression within elite cricket populations have been estimated [by way of self-report questionnaires] to be 38.4% and 37% respectively [20]. Such symptoms have been associated with prolonged recovery periods than expected, in those undergoing return to play protocols following sports related brain injury. At present clinicians treating those with a brain injury should be aware that reported mental illness symptomology could be associated with an exacerbation of pre-existing illness, a psychological response to the rehabilitation period or indeed a pure sequelae of brain injury for those affected. Perhaps even a combination of these. The importance of considering normal fluctuations in mental health should not be lost in this patient population [21].

Existing mental illness inquiry within the various post brain injury tools, endorsed by the leading cricketing administrations are inadequate in their present form. For example, within SCAT5 the patient will be asked to consider if they are experiencing symptoms “at this time” such as being “more emotional” and noticing “sadness”. These self-report symptoms are combined with a variety of other symptoms (such as dizziness, blurred vision, balance problems etc) to give a total symptom score and severity score.

Baseline SCAT5 examinations undertaken in amateur club rugby union players has shown promise as a possible screening tool to identify mental illness albeit with limitations in terms of generalisability to other sports, uncertainty with regards relevance to head injury history and heterogeneity [22]. The authors suggest that any patient suffering from predominant mental health symptoms will be unlikely to be identified as a result of the questions posed, at as yet, unspecified time points or intervals. Added to this, isolated self-report questionnaires without a fuller explanation, assessment and onward management of psychological distress can be harmful and lead to inconsistent practice. Future versions of assessment should look to optimise this area with evidence based practices and provide closer guidance on return to play strategies from a psychological perspective. Those with a history of concussion, existing mental illness or deemed to be at high risk of brain injury may benefit from psychological prehabilitation albeit this would be without any empirical evidence base at present.

## Conclusion

In summary, there are many factors influencing sports related brain injury, its diagnosis and management thereafter, with separate considerations for the amateur and elite level game of cricket. Use of video analysis will be an important aspect of the overall identification alongside existing methods of assessment, albeit with technology such as this unlikely to be forthcoming in lower levels of cricket. Thus, as knowledge base widens, dissemination of information related to brain injury throughout cricket should be prioritised moving forward and be to the forefront of education for not only medical professionals but the wider cricketering community. Mental health practitioners, be that sports psychiatrists, sports medics, neuropsychologists, clinical psychologists or otherwise, should be mindful of limitations within present assessment tools and understand the importance of a multidisciplinary approach in management of sports related brain injury in cricketering populations.

### Key points

1. Measuring performance related data when considering brain injury in cricket may work towards changing misguided or uninformed attitudes to traumatic brain injury within the game.
2. Within existing practices, limitations exist with regards short and medium term identification of symptoms and assessment, particularly from a mental health perspective.
3. Resources to assist practitioners have been made available by the major cricketering administrations.
4. Clear distinctions between the amateur and professional game need to be made and should not necessarily influence each other.

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# Scientific symposium of the International Society for Sports Psychiatry (ISSP), online, May 21st, 2023

The International Society for Sports Psychiatry (ISSP) hosted its annual meeting on Saturday May 21, 2023. The ISSP was founded in 1994 to advance the specialty of sports psychiatry and aims to carry the science and practise of psychiatry to the athletic community, to develop the field of sports psychiatry and to advocate for mental health and wellness and sports.

The meeting was held online and included a keynote address by eminent psychiatrist Dr Harrison Pope. Dr Pope has a long and distinguished career and is the most widely cited investigator in the world in the area of anabolic steroids. His presentation was a fascinating overview of the use of these drugs in sport and their impact on athletes.

This was followed by a scientific symposium of short presentations covering a range of topics reflecting new and important developments in the field of sports psychiatry. Topics covered included transcranial magnetic stimulation to treat depressive disorders, obsessive compulsive disorder, autism and eating disorders. There were also important presentations on mental health literacy, recent sports psychiatry educational initiatives and some reflections on cultural changes in basketball and their implications for the sports psychiatrist. *In the following abstracts, the speakers are underlined.*

## Abstracts

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### A1

#### **Designing culturally competent demographic questionnaires for mental health literacy research in semi-elite women's rugby**

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#### **Introduction**

Mental health literacy enhancing strategies require designers to be aware and understanding of diverse cultures to facilitate communication. The development of such interventions requires careful demographic data collection on protected characteristics to understand which individuals are most impacted by mental health symptoms and disorders and how information can be optimally delivered to them. This study examined a systematic approach to develop a demographic questionnaire for a study on mental health literacy amongst semi-elite women rugby players.

#### **Methods**

A three-pronged approach was taken to design a demographic questionnaire: 1) a review of demographic variables collected in elite sport mental health research; 2) a systematic review of studies that investigated prevalence of mental health symptoms and disorders amongst rugby players; and 3) a review of protected characteristics in the UK.

#### **Results**

A demographic questionnaire was designed to collect data on age, trans identity, sexual orientation, ethnicity, education, mental health history, and years of competition in rugby. Mental health literacy, general help-seeking intentions, distress, and wellbeing were also collected. 208 individuals participated in the study. Mental health literacy was significantly correlated with help-seeking intentions and was significantly higher amongst individuals with a previous diagnosis of a mental disorder.

#### **Discussion**

The collection of demographic information can be challenging and present ethically sensitive issues. Further strategies are necessary to understand how demographic

information should be collected. This may include the use of public involvement and pilot studies.

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## A2

### **A Sports Medicine Update to American Basketball: Contributions and Changes from Abroad and Implications for Sports Medicine and Psychiatry**

Ira Glick

*Department of Psychiatry and Behavioral Sciences, Stanford University School of Medicine, CA, USA*

#### **Introduction**

This talk updates our previous papers on psychiatric aspects of basketball, which had the aim of providing diagnostic and treatment implications for physicians doing Sports Medicine and Sports Psychiatry. Using articles from the sports media and from clinical experience, we update that broad overview from the European perspective. That is focusing on those athletes born in Europe or who have arrived in the U.S. born in Africa via Europe, who have in important and new ways changed the American game. As such, this is the first paper that details the European perspective for athletes, athletic teams, leagues, countries, and the sport itself. These athletes have changed the nature i.e., style, psychology, and medical-psychiatric aspects of this American game – changes which Sports Psychiatrists need to be aware of to improve treatment efficacy.

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## A3

### **The role of physical activity and sport in children and adolescents with Autism Spectrum Disorder (ASD) – review**

Agata Małgorzata Zborowska

*Disciplinary Domain of Medicine and Pharmacy, University of Uppsala, Sweden*

#### **Introduction**

The multiple health-related benefits of physical activity (PA) in children and adolescents are reported in several publications. Nevertheless, engagement in PA in the majority of youths is still insufficient, while the barriers for children with autism spectrum disorder (ASD) are still harder to overcome. This work aims to review the interventions using PA in the last five years regarding frequency and type of PA and narratively discuss their effect on psychological health in children and adolescents with ASD.

#### **Methods**

The searches were performed in PubMed (database) from October to December 2022 using Mesh Terms: “adolescent” OR “children” AND “sport” OR “physical activity” “mental health” AND/OR “autism”. The data were further critically appraised by PEDro and Cochrane’s ROB-2 graded in five stage categories of bias.

#### **Results**

There were ten papers included, reviewing different types of PA such as martial arts, jogging, aerobic exercises, and team sports in children with ASD. The major benefits of physical activity in children and adolescents can include social skills development, reduction of autistic traits behaviour and emotion management and regulation, and some of the studies reported specific neuropsychological domains such as working memory (WM).

#### **Discussion**

Evidence from the review suggests that PA can be an effective treatment in ASD, regulating emotions helping to manage behaviour and improving social skills. The proximal factor is the management of metabolic conditions, which can improve the biological predominance of autism, but also social factors.

## A4

### Expanding Sports MH Literacy and trained providers in Egypt: A Model for LMIC's

Dave Baron

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#### Introduction

The role of mental health in athletes has become an openly discussed and essential component of sports medicine. The care of athletes now includes assessment and treatment of behavioral health problems. High profile athletes from around the globe, representing many sports, have shared their personal mental health challenges, and the need to seek care. As a result, the field of sports psychiatry continues to grow, and the need for trained sport mental health professionals is expanding. This is particularly relevant in low and middle income countries (LMIC's), where there is a severe shortage of mental health professionals and very limited training opportunities in sport mental health. Adequately training a sports mental health provider requires more than an isolated lecture on depression and anxiety in athletes. The extant sports psychiatry textbooks highlight the broad MH topics, including those more unique to athletes, such as Doping and Eating Disorders in athletes. In addition, the need for collaboration between all stakeholders (athletes, parents/significant others, coaches, trainers, sport medicine providers, sports psychologists, league officials) is rarely discussed. Formal, well-organized training programs, like that developed by the ISSP, are needed to address this growing problem of limited capacity to provide mental health care to athletes in need.

#### Methods

Working with a local NGO in Cairo, a 16-hour course in mental health in sport was developed based on the book, *Clinical Sports Psychiatry: An International Perspective*. Content experts from ISSP were invited to give a 1 hour zoom presentation on their area of expertise, The course was 4 weeks, with a two 1-hour lectures given twice a week. The IT and logistics were developed and coordinated through Western Univ. of Health Sciences. The local NGO, WAAYS, advertised the course through word of mouth in Cairo, reaching out to universities and sports clubs. All students who completed the course were awarded a certificate of added training in sport mental health from WesternU and WAAYS. Feedback from all the students was obtained at the conclusion of the course.

#### Results/Discussion

32 students contacted the NGO expressing interest in taking the course. Students included Olympic athletes, Olympic coaches, psychiatrists, psychiatric residents, youth sport coordinators, parents of athletes, former athletes, and sports medicine providers. All 32 students completed the 16 hr zoom based course, earning their certificate. One week into the course, over 40 interested potential students contacted the NGO asking to join the course. Given the course was already 25% completed, they were told they would be put on a waiting list for future training programs. Students who completed the training have asked about developing a Masters in Sport Mental Health degree program, for added training and professional credentials. The post course feedback and evaluation was overwhelmingly positive, with the biggest complaint being a need for additional teaching sessions. One of the students, with no prior sports psych experience was offered to be a team sports psychiatrist for an Egyptian national team. Although ratings of individual lectures varied, all were viewed as good, most very good or excellent. The students rated the cultural sensitivity as very good, even though virtual all of the lecturers were not Egyptian. All of the students expressed a strong interest in becoming sport mental health providers.

#### Discussion

The need, and desire for, training in sport MH has been clearly demonstrated. As advanced training programs continue to emerge, the need to focus on LMIC's has been demonstrated. This type of training is necessary to expand capacity of MH care delivery in athletes at all levels of competition. ISSP and the WPA Sports Section, working together, can guide the future of training for sport providers around the world at all levels of competition. To quote Sherlock Holmes, *The Game's A Foot*. This is our time to provide our expertise and continue to grow the field of sport psychiatry and sport mental health internationally.

## A5

### Preliminary results of a systematic scoping review of disordered eating and eating disorders in student athletes in higher education

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## Introduction

Multiple risk factors are reported for eating disorders (EDs) and Disordered Eating (DE) in athletes (1), including athlete body ideals, societal pressures (2), and performance beliefs around leanness (3). Almost 4% of university students experience EDs (4); where the transition from home increases risks for ED and DE (5). Student Athletes face athletic and academic pressures in combination (6). A recent scoping review reported 29 citations covering EDs and DE but the current evidence appeared incomplete (7). The purpose of this review was to comprehensively examine the current literature about EDs and DE in student athletes, understand methodological characteristics, results and output trends, and current knowledge gaps.

## Methods

Articles from SPORTDiscus, PsycInfo, MEDLINE; grey literature (through British Library), ProQuest, Web of Science, medRxiv, and Europe PMC were searched for primary research on ED or DE in student athletes (8).

## Results

4309 citations were returned, following title and abstract screening, 550 underwent full text review and 250 met inclusion criteria for data extraction. Most studies were from the USA with a cross sectional design with limited control subjects. Majority were questionnaire surveys using multiple questionnaires with responses reported as mean and SD or individuals above threshold. Multiple different terminology was used in outcome reporting making comparison between studies difficult.

## Discussion

Methodology and reporting standards are heterogenous with most studies in the USA and few studies looking into wider environmental pressures experienced by student athletes. A study is underway attempting to understand DE in UK student athletes from an academic university and one known for elite athletes is in early stages also looking at social media use, financial pressures, the food environment using quantitative and qualitative methods.

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## A6

### Obsessive Compulsive Disorder in Sports: Beyond Superstitions

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## Introduction

The concepts of superstitions, routines, and peculiar behaviors in sports have been well characterized and sometimes associated with “obsessions” and “compulsions.” These are distinctive from pre-performance routines, which are learned cognitive and behavioral strategies intentionally used to optimize and enhance sport performance. We see this behavior in fans, with routines and superstitions geared to help their team rally or win. Although these actions are often performed with the belief that they influence the outcome of the competition, there is no actual relationship to the outcome. There have been numerous studies characterizing the nature and frequency of superstitions, repetitive behavior, and obsessive and compulsive features in athletes, however few studies report on the impact of obsessive compulsive disorder in sport. Key differences between concepts that will be presented. This presentation will describe how obsessive compulsive disorder presents in athletes and its impact on the experience of the athlete and the sport environment. Comorbidities and management approaches will also be explored.

## Methods

Extensive literature review, correlated with clinical experience.



## Results and Discussion

OCD is distinctly different from superstitions, sport rituals, and preperformance routines in their definitions and functional impact. Obsessive compulsive disorder is a chronic illness that can significantly impact function and quality of life beginning in childhood. While most of the obsessions and compulsions are experienced privately, more severe forms can spill into professional and sport settings. When this happens, the athlete, training environment, team staff, and facility staff may be impacted by the symptoms. Specific sport-focused manifestations of the most common obsessions and compulsions can be anticipated, and the presence of symptoms should trigger assessment. Comorbidities are common and influence the course of treatment and outcomes. Untreated OCD can have a chronic and debilitating course. Safe and successful treatments are available for OCD and its comorbid conditions, and early identification of these symptoms may lead to earlier treatment and mitigate the development of more severe pathology. Future research is needed to explore epidemiology and treatment outcomes of OCD in the athlete population.

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## A7

### Sports-Related Concussions and Resistant Depression: Transcranial Magnetic Stimulation (TMS) as a Treatment Option

Debra Stultz<sup>1</sup>, Tyler Burns<sup>1</sup>, Savanna Osburn<sup>2</sup>, Thomas Gills<sup>1</sup>, Christina Shafer<sup>1</sup>, Robin Walton<sup>1</sup>, Star Michelle Roe<sup>1</sup>, Summer Pemberton<sup>1</sup>

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## Introduction

The lifetime prevalence of depression after a traumatic brain injury/concussion is 25–50% (1). Some athletes can be subject to one or more concussions throughout their careers, increasing their risk of depressive episodes. Kerr et al. 2012 studied 1044 members of the National Football League Retired Players Association between 2001 and 2010 and found that 10.2% of the respondents (106/1044) reported being clinically diagnosed with depression at some point over the nine years (2). Approximately 65% self-reported at least one concussion during their careers. Kerr et al. wrote, “the association between concussions and depression was independent of the relationship between decreased physical health and depression.” Traumatic brain injury patients may be resistant to pharmacotherapy. In addition, athletes may have more limited medication options to treat depression and may have concerns about the potential impact of medication side effects on performance. Transcranial Magnetic Stimulation (TMS) is an FDA-approved treatment for depression and may be a beneficial alternative to pharmacotherapy in those with resistant depression.

## Methods

This case is a 23-year-old male with a history of 4 sports-related concussions while participating in high school sports, resulting in two hospitalizations. He had resistant depression, had previously tried various psychotropic medications, and had participated in CBT. Due to the resistant nature of his depression, TMS was initiated.

## Results

The patient received 34 transcranial magnetic stimulation treatments with the H-1 dTMS coil at 120% MT to the left DLPFC while following the Beck Depression inventory and the PHQ-9. The patient demonstrated an improvement in his Beck Depression Score from 33 to 21. His PHQ-9 score decreased from 15 to 10. He tolerated the treatment well, without a seizure.

## Discussion

TMS is an approved treatment for depression and may be an attractive alternative for some athletes. In particular, it can be considered for those resistant to other treatments and those who have experienced significant side effects with medication especially where these could interfere with athletic performance.

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## A8 Integrative Eating Disorder Theory of Etiology

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### Introduction

There have been several breakthroughs in understanding etiology of eating disorders (ED) in recent years. This information has not translated into improved treatments. In an effort to usher in a new age of research this article aims to integrate concepts from different specialties and provide a cohesive etiology of EDs as a plate form for future collaborative research to springboard from.

### Methods

Search Emory and Georgia Institute of Technology virtual library.

### Results

180 studies were reviewed 104 were not included because the date of the search parameters were narrowed down to 2009 to present. Another 20 were excluded because the articles did not focus contribute to the understanding of EDs. We included 56 studies across different specialist in this article.

### Discussion

In the ancient Indian medicine called Ayurveda the concept of the gut-brain axis has long been delineated. As is true in all of mental health illnesses, balance and lifestyle modifications (physical exercise, self-care, quality balanced diet, good sleep, and work-life balance) are protective against EDs, can help in treatment of EDs, and maintenance of recovery from EDs. Many of the techniques discussed here are designed to help restore balance. However, balance means different things in different individuals based on their characteristics and the characteristics of their ED. This creates limitations in the ways in which ED treatments are studied and verified. EDs are very complex which have lead us to have multidisciplinary treatment teams with minimal success outside treating the family (which in children is equivalent to treating lifestyle). I recommend multidisciplinary research ideas to tackle this complex diagnosis.



# Tackling racism in sports psychiatry

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**Abstract:** Racism is embedded in society and, therefore, in sports. This paper summarizes the long history of racism directed at Black athletes in the United States, the various ways that racism is manifest in sports, and the psychological impact of racism on individual athletes. Suggestions for addressing racism in the clinical setting as well as in the athletic environment are presented, along with several clinical vignettes. Because racism affects everyone, it is suggested that clinicians advance their self-awareness and knowledge of the problem, and several avenues for doing so are presented. It is suggested, in addition, that the topic of race be included in the therapeutic agenda while keeping in mind that it is the patient's prerogative to determine when race is relevant and when it is not.

**Keywords:** tackling racism, racism in sports, Black athletes in therapy, racism and sports psychiatry, racism and sports psychology

## Background

Racism, the inflicting of harm based on a person's perceived race, is a peculiar phenomenon. On the one hand racism is completely irrational, while on the other, its perpetrators often display no symptoms of mental illness or defect. In its history, racism has led to extreme cruelty inflicted on innocent people, and yet racism has proven to be nearly impossible to criminalize and punish. The insults, deprivations and humiliations that are immediately apparent to the victims of racism are often entirely obscure to its perpetrators, and persons who harbor no obvious racial animosity may unintentionally contaminate even ordinary human interactions with racist ideas and assumptions. While racism most often attributes qualities of inferiority to the targeted race this is not exclusively the case. Racism may be based on envy of qualities that are admired and thought to be especially embodied in persons of a particular race, who are then despised for it. The effects of this peculiar phenomenon can be seen throughout society - in law, education, employment, housing, health care, science, and politics, among others. Sadly, racism also infects that realm of activity that is sometimes considered to be an island of fairness and objectivity, the world of sports.

This essay is addressed to mental health practitioners who work or intend to work in sports. Embedded as it is in society, racism is embedded in sports as well, and its impact there will be felt by those people under our care who have been subjected to it. In one respect, the experience of racism is like the experience of any other individual trauma, requiring that we help our patients to separate who they are from what has happened to them. In another respect,

however, the experience of racism transcends individual trauma because it is collective, perpetrated by groups upon other groups over the course of generations.

As a collective trauma racism has generated massive injuries that can be measured in many ways, by life expectancy rates, for example, or by criminal incarceration statistics [1]. Those who have been injured by racism, in response, have developed collective strategies in order to endure and rise above it [2]. Racism is embedded in history and society so deeply that all of us have been affected by it to some degree, regardless of our own intentions or the intentions of those who raised us. Understanding the effects of racism on ourselves is no easy task, for it requires us to accept that our thinking has become distorted and harmful to some degree. Overcoming racism in sport psychiatry, therefore, requires that we deepen our knowledge of racism and patiently explore the impact of racism on ourselves as well as on the people under our care.

We will focus here on aspects of racism primarily in the United States, and primarily perpetrated by whites against Black athletes. We do not wish to minimize the horrors committed against Indigenous persons, persons of Asian or Pacific Island descent, nor of anyone anywhere worldwide who may be identified as a person of color. Racism inflicted by whites upon Blacks in the U.S., however, may be paradigmatic of racism everywhere and is therefore an instructive object of study.

In addition, we will not dwell here on signs of progress. Some sports organizations, such as the National Basketball Association, seem to be addressing racism in their ranks and in society, and various white commentators, athletes, coaches and officials have been supportive of Black

athletes over the years. The perspective of this essay is clinical, however, and just as we would never advise a patient who was verbally abused as a child to be thankful that they were not beaten, we do not wish to dilute the severity of the problem.

## Historical antecedents: The odyssey of Jack Johnson

In the United States, racism in sports has an enduring and multifaceted history that would be impossible to summarize in a few short paragraphs. This history includes:

- formal and informal methods to exclude Black athletes from participation [3, 4],
- explicit derogation of Black athletes in prominent and respected periodicals and newspapers [3, 4, 5],
- outbreaks of mob violence against Black citizens in the wake of successful performances by Black athletes [2, 3, 4],
- punishment of Black athletes who choose to speak out against racism [6],
- evaluating athletic performance on the basis of race rather than ability by coaches, administrators, and institutions [7],
- harassment of Black athletes who break racial barriers in sport [4, 8],
- attempts to suppress news of Black athletes' successes [4, 9],
- the erection of socio-economic and academic barriers to participation by Black athletes [10],
- maintaining barriers to the appointment of Black officials, administrators, coaches, and support staff to athletic organizations [11],
- systematic under-representation of Black professionals in organizations that serve the athletic community [12].

In order to illustrate several aspects of this history we will focus here on Jack Johnson, the world's heavyweight boxing champion from 1908 to 1915. Johnson was a target of relentless racist activity in his lifetime. His great success in the ring landed him in prison and triggered a widespread outbreak of anti-Black violence. He became a symbol but attempts to encapsulate Johnson in racial terms greatly distorted who was as a person. Johnson was erudite, multi-talented, complex, and not racist himself. His life, in fact, exemplifies the stark contrast between who a person is and what that person represents, a contrast that lies at the heart of racism.

Johnson was born in 1878 in Galveston, Texas, one of five surviving children of parents who had formerly been enslaved. He attained a local reputation as a skilled fighter

in his early teens and, with time, fought in ever larger circles throughout the United States. He won the heavyweight championship in 1908 in Sydney, Australia, over Canadian boxer Tommy Burns, whose real name was Noah Brusso, and whom he had stalked and challenged in Europe and elsewhere before convincing him to fight. The bout was totally one sided. Video shows Johnson laughing and chatting with the crowd, holding Burns up as Burns hurled racist insults at him. Johnson remembered glancing "again and again" at a "colored man" in the crowd, who "became sort of a landmark" for him [5]. As Johnson was preparing to knock Burns out, the local police stepped into the ring, stopped the fight, and ordered the cameras to stop recording so that people around the world would not witness a Black man being crowned champion. Burns' ironic prediction that he would whip Johnson "or my name isn't Tommy Burns" held true, and in a preposterous claim Burns later said, using a common racial slur, that the fight should not have been stopped at that point, for Johnson was "tiring fast" [5, 13].

Almost immediately the search began for a "Great White Hope", the actual term used at the time, to defeat Johnson. A former champion, Jim Jeffries, was convinced to come out of retirement and a bout was held in Reno, Nevada, on July 4, 1910. Johnson, chatting and joking with the ringside audience as usual, knocked Jeffries out in the 15th round. Later, he said that Jeffries fought with great courage, while Jeffries, in spite of having made many racist comments over the years conceded that "I could not have whipped Johnson at my best. I could not have hit him" [3].

The eruption of racism was immediate and violent. White mobs around the U.S. attacked the celebrating Blacks, killing dozens. Theaters refused to play footage of the fight. Vitriol poured forth in the press. Terms like "savage," "animal," and worse were used [3, 4, 5]. Accusations were made that the fight was fixed. A coordinated effort by federal and local law enforcement to punish Johnson resulted in his eventual conviction for sex trafficking based on the coerced testimony of a former girlfriend. The indicting grand jury was overseen by Judge John Kenesaw "Mountain" Landis, who later enforced the color ban in baseball as commissioner.

With the blessings of his mother, who said that she would rather never see him again than to see him, in his words, "hemmed in by the stone and steel of prison walls and gates," Johnson fled the country [5]. In an adventurous six-year exile, he defended his championship abroad, socialized from London to Moscow with prominent people in politics, business, and the arts. He learned bullfighting in Spain and was caught in the crossfire of World War I at its beginnings. During this time he agreed to lose a fight against Jess Willard, in Havana in 1915, with an understanding that he could then return home without going to prison.

Though there are some who say that Johnson was beaten fairly by Willard, video shows him shading his eyes from the sun while lying on the canvas, a posture not seen before or since in a person who was knocked out. At the moment the referee counted to ten Johnson arose and casually left the ring [3, 4, 5].

The promise of avoiding jail time was broken, and Johnson eventually returned to the U.S on July 20, 1920. He surrendered to authorities and served 10 months in Leavenworth Federal Prison. His mother had died before she could see him again, though she was spared the pain of seeing him imprisoned. Nearly a century later Johnson was pardoned, after years of lobbying by his descendants and admirers, by President Donald Trump.

Johnson's life is contemporaneous with the era of Jim Crow, when concerted efforts were made throughout American society to reverse the effects of Emancipation and Reconstruction. It is in this era that so-called "literacy tests," poll taxes, and property ownership requirements for voting were imposed, when the Supreme Court established the "separate but equal" doctrine in *Plessey v Ferguson* [14], and when monuments to so-called heroes of the Confederacy that are being taken down today were erected. In the decade of Johnson's rise to the championship there were over 800 documented lynchings of Blacks in the United States [15, 16]. These lynchings were often carried out as festive events attended by local white families who brought their children and packed picnic lunches. So acceptable had racism become that one of the first acts of Woodrow Wilson on assuming the American Presidency in 1912 was to impose segregation by race throughout the offices of the Federal government [13].

This activity was mirrored in sports. Although fourteen of the fifteen riders in the inaugural Kentucky Derby of 1875 were Black, and Blacks continued to dominate that sport for several decades, Black jockeys were becoming extinct by the time Johnson became champion. There was never an explicit ban, but by methods that included the denial of licenses, life-threatening intimidation by white jockeys during races, and repudiation by owners, Black jockeys were expelled. Other sports, such as Major League baseball, also became completely segregated through a blend of written policies and informal agreements. From time to time whites stood up to these racist policies. John McGraw, manager of the Baltimore and New York Yankees in the early 1900's refused to obey baseball's color ban. Theodore Havermeier, the president of the United States Golf Association, insisted that the second national championship of 1896 would take place with only its two Black entrants if white golfers made good on their threat to boycott. But these efforts generally failed. It was not until 1960, in fact, that the "Caucasian Race" requirement for membership in the Professional Golfers Association was

declared unenforceable in California by an order of that state's Attorney General Stanley Mosk, a full six years after the supreme court reversed *Plessey* in *Brown v Board of Education* [3, 4, 17, 18].

In spite of these circumstances Black athletes continued to compete. Some athletes managed to perform in racially integrated settings. Fritz Pollard, for example, a graduate of Brown University and protege of John D. Rockefeller, managed to find his way to professional football before that door closed. Other athletes, including Josh Gibson, in the Negro Leagues of baseball, and John Shippen, of the United Golfers Association, had extraordinary careers in all-Black competitions. As racial barriers came down piecemeal after World War II a number of athletes, including Wendell Motley and Night Train Lane from the military, and Jackie Robinson and Roy Campanella from the Negro Leagues, were able to play in previously segregated leagues. Throughout this period, however, Black athletes were subjected to taunts, threats, segregated facilities and race-baiting. Tidye Picket, who qualified for the Olympics in track and field in 1932 was doused with water while sleeping on the train to Los Angeles by one of sport's legendary female heroes, Babe Didrickson [3, 4, 8].

In accounts of the lives of these athletes we can often discern a tendency to describe them as racial symbols rather than as unique individuals in their own right. For example, Jack Johnson's choices in life are often portrayed as reactions to white society rather than personal preferences. His love of beautiful clothes and exotic cars reflects a desire to exceed whites, we are told, rather than as a reflection of his personal taste [19, 20]. His dating of and marrying white women is understood as an act of racial defiance rather than, as he explains in his autobiography, a reaction to a sequence of crushing betrayals by two Black women he loved [5]. In a manner that will be immediately familiar to any Black person, let alone any Black athlete, Johnson has been described as "addicted to attention . . . cunning . . . crafty . . . charming" [19, 20], and as being "not too concerned with literal truth, or why he should scrape and bow to the mundane world of fact" [19]. A literary figure straying somewhat outside of her area of expertise declared him to be "one of the two most intelligent" of all American boxers [20]. He has also been portrayed, finally, as a Black man whose spirit was broken by the white society that hunted him [9, 19, 20].

The actual Jack Johnson was quite different. One person who knew him well described him as a man of "mature judgment" and "keen insight", gifted physically and intellectually, loyal to friends and kind to strangers, and able to face a tumultuous and often hostile world with good humor and wisdom [21]. Johnson spoke Spanish and French fluently, read the works of Hugo and Dumas in their original French, and was conversant in the plays and sonnets of

Shakespeare from which he could quote extensive passages. He was an accomplished musician who played his upright bass as means of relaxation during training. He collected fine art. While at Leavenworth Johnson applied for and was granted a patent, one of two in his lifetime [22, 23]. His frivolity and association with what one writer called “the pleasure-loving world. . . of a boxer”, that is, fast women and fancy cars, would have evoked admiration in a white man while evoking “arduous condemnation” of Johnson, condemnation whose onslaught he faced with “courage and confidence” [21].

Far from being a broken man after his exile and imprisonment, Johnson is described by various observers as being in fighting shape, and, in his fifties “happier than he has ever been,” even without the wealth and fame he once enjoyed. He was almost fifty, in fact, when he wrote his autobiography, one of only two professional athletes who, as far as we know, wrote their own rather than turning to ghost writers [24, 25]. This autobiography, “In the Ring and Out”, is worth reading on its own merits. It is characterized by refined, almost aristocratic prose, flashes of understated passion, extended passages of wry humor, and an abundance of informative historical detail [5]. Several attempts to disprove the content of the narrative have failed, although an occasional inaccuracy has fed the appetite of some to prosecute Johnson for dishonesty [20]. The range and depth of Johnson’s interests and accomplishments may be what even today stokes the genteel envy of some white commentators.

## The varieties of racism in sports

Racism is racism and subdividing it into categories does not make a great deal of sense, particularly to those at whom it is aimed. However, it may be useful to follow tradition and classify several types of racism for the purpose of recognition, explanation, and remedial strategy, while keeping in mind the unity of the phenomenon and its extension beyond sports.

Among the varieties of harm that are inflicted on people because of their perceived race, four stand out.

- The first is violent racism that aims to kill, injure, or terrorize without apology or regard for what is right or wrong, good or evil, and that is based purely on hatred, fear, or envy.
- The second variety of racism is “systemic” racism, sometimes called “institutional” racism or “structural” racism. This refers to racism that is embedded in the laws, policies, or customs that govern the behavior of groups of people and that inflicts its damage either through the intentional targeting of race or through indirect effects that have differential racial impact.
- The third type of racism is what we could call “sneaky” racism. This is racism that is cloaked in an air of respectability but is unambiguous in its intent. It includes acts of racial profiling, discriminatory decision making, and the signaling of racist messages thinly disguised as something else, or “dog-whistling”.
- The last type of racism we could call “surprise” racism, though it is hardly ever a surprise to those who have seen it many times in their lives. Sometimes termed “implicit” racism that is identified by “microaggressions”, this type of racism is composed of the acts, gestures, and statements of individuals that express racist assumptions, offend its listeners, and contaminate what is otherwise routine discourse.

These types of racism overlap.

In sports, systemic racism exists at all levels: youth, college, professional, elite amateur, and recreational. In Milwaukee, for example, a city that is 40% Black and where club soccer is run by suburban white families, it is rare to find more than one or two Black kids on a team, while Latino kids compete in their own leagues. In the realm of professional sports, consider American football. While 70% of pro football players are Black, there are only three Black head coaches out of 32 teams as of this writing [26]. For the 2021-2022 season six head coaching positions opened up to be filled, but no Blacks were hired even though one highly respected Black candidate had been the offensive coordinator for a Super Bowl Championship team and had interviewed for all six of these positions. Prior to the 2022 season the applicant for one head coaching job received a congratulatory text message from his mentor that was mistakenly meant for a white applicant who had been hired before that Black coach had even received his sham interview [27].

When we look at the position of quarterback, who is the fulcrum of the offense and its most visible player, we see all forms of racism at work. Volz found that Black quarterbacks in the National Football League are more than twice as likely to be benched as white quarterbacks when performance factors are controlled for, and that team performance is more likely to improve when white quarterbacks are benched than when Black quarterbacks are benched [7]. This reflects a longstanding systemic bias that was established in the early years of the NFL under the leadership of George Preston Marshall, an avowed racist and owner of the Boston Braves, a franchise later renamed the Redskins.

Fritz Pollard, who played quarterback as well as coaching his team, retired in 1932, and it was not until 1949 when George Taliaferro was drafted as a single-wing quarterback that a Black player again occupied the role [4, 28]. After Taliaferro, Black athletes entering the NFL as quarterbacks

were routinely moved to wide receiver or defensive back. Dennis Franklin played quarterback for a University of Michigan team in the early 1970's that lost only two games in his three years. In a conversation with the author (September 2022) he reported that he felt "protected" from racist vitriol by his white coach, Bo Schembechler, but was immediately switched to wide receiver upon entering the pros. Marlon Briscoe, a quarterback known as "The Magician," rescued his Denver Broncos when several quarterbacks ahead of him were either injured or benched for poor play during the 1968 season. Although embraced by an offensive line composed of white southerners whose motto became "Don't touch the Magician", he was not one of the seven quarterbacks invited to pre-camp the following year and was traded. In retirement Briscoe earned Hall of Fame honors as a defensive back [29]. Warren Moon, who had a distinguished 20-year career, was obligated to establish himself in Canadian football before being accepted to the NFL [4, 28]. Doug Williams, who in a spectacular four touchdown second quarter performance led his Washington Redskins to a Super Bowl championship in 1987, was benched the following year. Charles Ward, a quarterback and two sport athlete who won the Heisman Trophy as the outstanding college player in 1992, went undrafted that year and opted to play professional basketball instead [28]. In 2022, Kyler Murray, an accomplished professional quarterback, was asked to sign a contract containing a condescending requirement that he spend a certain number of hours in weekly study, a clause that was quickly rescinded when it became publicly known [30]. Various aspersions have been summoned over the years to justify these decisions, buttressed by prevailing attitudes revealed in common speech. Billings, in 2004, analyzed 3,800 descriptors of Black and white quarterbacks by television commentators and found that the success of Black quarterbacks tended to be ascribed to their athletic ability while the success of white quarterbacks was ascribed to their intelligence [31].

A recent trove of emails discovered in a legal dispute among NFL owners of the Washington Redskins has revealed one explicit example of concealed racism in professional football. A nexus of racist, homophobic, and misogynist opinion was shared over many years between a highly respected and successful coach, a prominent individual within the NFL hierarchy, and one owner of the team. Despite his obviously racist mockery of the appearance of a players association executive, the coach in question claimed in his qualified apology that he didn't "have a racist bone" in his body [32, 33]. Often he had spoken of his high regard for Doug Williams, but as one athlete put it, "they love you as much as you can entertain . . . dribble a ball . . . catch a pass" [34].

Examples of systemic, sneaky, surprise, and violent racism abound in sports and can be cited by any Black athlete under our care, observed by any of us in our daily work, or read in any contemporary account of the experience of Black athletes. An agreed upon compensation schedule for retired professional football players suffering from chronic traumatic encephalopathy sets a more severe qualification standard for Black athletes than white athletes on the assumption that their cognitive skills are intrinsically lower [35]. A groundskeeper at a track and field venue turns to a psychiatrist who is speaking with a Black athlete and asks if he "smells a skunk". A clerk in a high-end jewelry store locks the front door with an emergency switch and calls the police at the sight of a Black professional athlete wishing to shop. Two college track athletes are stopped and frisked while heading to their white academic advisor's home for a holiday gathering. A high school athlete is benched for clapping too loud and too long after a performance in class, another is accused of plagiarism, another is interrogated about the source of his ticket for a basketball game at his own school. As far as we know, there is hardly a single Black individual growing up in the United States who has not been called by an ugly racial slur, whether by a roaming mob, a person in some sort of authority, or a passing car. There are very few who have not been stopped by police for being Black, a terrifying event that can quickly escalate [34].

## The impact of racism on Black athletes

Although racism has been discussed as an enduring problem in the sport psychiatry literature [36], virtually no controlled studies have been published that measure the impact of racism on the mental health of Black athletes. Because of the fact that the standardized environment of sports yields an abundance of "experiments of nature," in which subjects are inherently randomized to experimental and control groups and contaminating variables are reduced, such a study would be easy to conduct. One would merely need to compute correlation coefficients of race with coaching decisions and administer serial measures of mental well being. According to data compiled by the Centers for Disease Control and the National Institutes of Health, however, of nearly five billion dollars spent on mental health research in 2019, none of it went toward research on this problem [37].

Innumerable anecdotal reports, however, that describe the impact of racism on Black athletes, along with journalistic accounts, case reports, clinical experience, and word of mouth, paint a disturbing picture. In order to sidestep

the knotty issues of etiology and diagnosis that plague psychiatry we will simply list here some of the common-sense categories into which the personal impact of racism falls.

## Confusion

A college gymnast faced a decision during an Olympic year. As a dual citizen her choice was between competing for her African country of origin, where she was likely to achieve a qualifying score in regional competition, or trying out for the United States team where her chances were not strong. Her white coaches pressed her to compete in the United States trials, and while her goal was simply to compete on the highest stage with the world's best athletes, she opted to follow their advice and failed to qualify for the team.

## Humiliation

An extraordinary high school quarterback was told during a college recruiting visit that he would have a fair chance of becoming the team's quarterback were he to attend the school. Upon joining the freshman team there he was placed on defense, however, and consigned to a third team running back role on offense. In class he was shocked to be accused of plagiarism, a word he hadn't previously known, for an essay he had written on a Shakespearean sonnet in which he compared Shakespeare's iambic pentameter to the rhythm of waves on the shore, an analogy that happened to be identical to that of an obscure literary scholar. He felt "flushed in the face" daily, and came close to quitting. This athlete managed to remain in school only with the encouragement of his father, who had narrowly escaped being lynched as a young man, who had been unable to read and write until being taught by his wife, and who valued education above football.

## Injury

A high school volleyball player was benched early in the season in favor of a white outside hitter well known to be both inferior to the Black athlete and the daughter of a friend to several prominent members of the private school's board. In her discouragement she failed to carry out her usual warm up for the ensuing practice, tore her labrum in one of the drills, and was lost for the rest of that season.

## Sorrow

A high school basketball player, seasoned on the courts and gyms of New York City, moved to a small Southern town and tried out for the team at his new, predominantly white high school. It was his hope that playing basketball

would enable him to make friends in this new place, but neither he nor any of the other Black students who tried out for the team made even the junior varsity. Years later he spoke of arriving home, crying uncontrollably in his father's arms, and giving up basketball for good.

## Sustained sorrow

Years after enduring a barrage of racist insults and death threats a football player cries quietly at the memory during his Hall of Fame Induction ceremony.

## Neglect

A collegiate long jumper, who because of his reticence had been labeled vain and arrogant, broke a school record by more than a foot. When it was pointed out to him that his jump was unusually high compared to his others, he replied "Thanks. My coaches would never have told me that."

## Frustration

A lacrosse player missed a competition while attending a student conference on climate change and was held out of the next game as punishment. Teammates who missed for religious reasons were not similarly punished.

## Frustration and rage

A sequence of questionable calls were made by a respected chair umpire against a Black tennis player in an important match. So obviously wrong were the calls that the umpire was removed from the tournament. Several years later another umpire called a service foot fault against this player at a crucial moment, a call that was universally condemned by knowledgeable commentators. This athlete, a target of biased officiating periodically in her career, erupted. In a profane outburst she threatened to shove a tennis ball down the official's throat.

## Rage

A professional basketball player known as a "good citizen", struck and broke the jaw of an opposing player who was white, explaining that "the guy deserved it". Earlier that day the athlete had attended the sentencing hearing of a white man convicted of manslaughter for running down his father, whose car had run out of gas and who was walking by the side of the road to the nearest gas station. When the player was kicked out of the game, he went to the locker room and broke down for the first time since his father was killed.



## Inspiration

A group of middle-school athletes played basketball for both an AAU team and their predominantly white school. In the school games, a peculiar cycle repeated itself. The white kids who started the game fell behind, the Black kids came in and built a lead, and the white kids returned to either lose the game or hang on to win. This pattern was so obvious that even the white coach of the AAU team commented on it. Moving on to high school the next year, several of the kids refused to play for the school team, whose moniker, the “Rebels,” was often honored with the waving of confederate flags. One of these athletes became the analytics analyst for a large voting rights organization and a volunteer in several vigorously anti-racist initiatives.

## How to tackle racism in sport psychiatry

As with many articles that we read in professional journals and online, this one may contain some inaccuracies and debatable claims. The existence of racism in society and in sports, however, and the harm it does to the athletes we treat, is indisputable. To combat it we must understand that racism reduces another person to a symbol of something, usually something deficient. The complexity, style, concerns, personal history and evolution of the other person become irrelevant. Whether it is manifest in violence, in systematic harm, as a sneaky attack or as a surprise, the aim and function of racism is always to diminish, and ultimately, to dehumanize.

Here are a few suggestions for tackling this problem. It may seem that these suggestions apply only to white psychiatrists and mental health professionals but that is not exclusively the case. Racism touches everyone, and while Black professionals have a familiarity with it that whites can never acquire, the impact of racism can be nuanced, circuitous and paradoxical. Each reader may assess which suggestions, if any, apply to them. Several of the suggestions below are illustrated by hypothetical clinical scenarios. Although based on real events, these scenarios are embellished with fictional details and scrubbed of identifying information. They are presented as food for thought.

## Educate yourself

No matter how much we know or think we know about racism in America we can always learn more. We can find information online that exposes the falsehood of some commonly held prejudices, such as that of the absent

Black father [38]. There may be a Black-owned bookstore in our city, where we can browse the collection and ask for recommendations, reading not just about slavery, racism, and damage, but also about the heritage of Black culture [2, 5, 39, 40].

In furtherance of our education, we can make a deliberate decision to participate in activities of the Black community. If we are religious or spiritual, we can go to a predominantly Black church. If motorcycles are our thing, we can invite ourselves to a gathering of a Black motorcycle club. There are numerous art galleries, restaurants, cultural events, musical venues, and other settings to visit that embody an African American idiom. If you are white and have had a segregated upbringing you may be a little uncomfortable at first. You may say something stupid. You may feel like an intruder or a spectator. Someone may ask if you are lost. Don't worry. These things will pass, and you are likely to make new friends, who will then take your education to a deeper level.

Consider enrolling in a workshop aimed at addressing racism. There are many of these available, and various institutions hire consultants to run them. There is a significant body of work assessing the impact of these programs and they have shown two things. First, these programs are most effective when they are conducted in a series over the course of weeks or months, rather than as an intensive one or two day workshop. Second, unless they adequately address the unconscious biases of the participants the lessons don't stick [41].

## Bring it up

As the therapist, you set the parameters of your treatment sessions, and your Black patients will appreciate your putting race on the agenda. Whether you are white, Black, or other you don't have to hit your patient over the head with it the moment they walk in the door, but bring it up. Some Black patients will prefer a Black therapist. It is understood. Others may at some point give their white therapists a feeling that race is an issue, though they may feel that the therapist will not understand and fail to speak of it. For still others, race simply won't matter. There are a variety of ways to introduce the subject of racism, but having made it explicit, let it go and give the patient the opportunity to take it wherever they feel comfortable. Over time you will develop a mutual understanding of where race is relevant and where it is not.

### Clinical scenario 1

The volleyball player mentioned above who was unjustly demoted from her starting position and tore her labrum becomes despondent and is brought to therapy by her parents. Her father, who holds a position of corporate

authority in the entertainment industry, is well versed in practices of favoritism and connections, having managed to overcome these in the course of his career. Both parents assure their daughter that her replacement “is not about you”, but as her depression deepens they decide to seek help. In the initial meeting, which the parents join for a time, the therapist asks if race may have been a factor and is met with a shrug of indifference. Most important is the impact on their daughter.

As the individual meetings progress it turns out that there is another source of pain aside from the unfair demotion itself. The girl who replaced the patient in the lineup had been a close friend, and the decision to elevate her in the lineup introduced an impassable rift between the two and a feeling of deep loss and betrayal. Hearing this induces a mixed feeling of sadness and quiet outrage in the therapist, and he asks why it is that the “other outside hitter” isn’t benched, or at least put in some kind of rotation with the patient. In fact, there is no “other outside hitter” in volleyball, but rather an “opposite” who appears to the average viewer to perform the same function. Without correcting the terminology of her therapist the patient answers, “because she’s white, too”.

## Confess your sins

If you are white and you have grown up in America, you will definitely put your foot in your mouth. You may inadvertently bring a topic back to race when race is irrelevant, you may reveal a prejudice you harbor about what Black people are supposed to be like, or you may express skepticism that particular events are race-based by pointing out that similar things happen to white people. If you have created an open dialogue in the office, on the field, in the training room, or in any of the places we work in sport psychiatry, your patients will point out the racism in your behavior, sometimes humorously and sometimes angrily. Don’t deny. Believe what you hear. Confess. As Carl Whitaker said, “If I myself am not healing, how can I expect my patients to heal?” [42].

## Take a stand

Because of the polarization in society over race, the multiple disguises of racism, and the persistence of racist ideas and structures, we will be required at some point to take a stand if we wish to work effectively with Black athletes. An obvious way is to join anti-racist initiatives in the professional organizations to which we belong. A more difficult path involves confronting, when we see it, episodes of sneaky racism in casual conversation with coaches, administrators, and players within the sports teams to which we consult. If we are white, these events may take us completely by

surprise, as when a conversation with white coaches, athletes, or administrators about a mundane topic inexplicably turns to the character defects of one Black athlete or another. References to an athlete’s natural ability, powerful mother, broken home, laziness, and other racist tropes may be tricky to call out. In our experience Black folks are better able than white folks to respond to these situations since they have experienced them repeatedly, recognize them quickly, and know what to say. For white therapists, some role-playing in advance may help to craft responses to keep in readiness. With well-meaning people, a little piece of information often goes a long way.

## Clinical scenario 2

The lacrosse player who was punished for missing a meet to attend a conference on climate change decides to skip a few days of school in protest, and is then suspended by the school pending a disciplinary conference. The school officials, with the permission of the athlete’s parents, contact the psychiatrist who prescribes ADD medication for the athlete, asking for some sort of medical excuse to make the issue go away quietly. In consultation with the family, the psychiatrist declines to provide this and instead shows up to the disciplinary conference where she “testifies” to the sincerity of the athlete’s commitment to fighting climate change, a subject that had casually come up often during the medication visits, and where she also expresses her skepticism of the rationale for punishment.

## Prepare for resistance and hostility

Black or white, if you call racism out you are likely to meet resistance or retaliation from somewhere. The resistance may be as mild as a “factoid”, such as that nine of the NFL’s 32 starting quarterbacks at the season’s open in 2021 were Black, presented to undermine a well-documented premise. Or it may be more comprehensive.

In the context of the Black Lives Matter movement a small organization devoted to providing medical services to athletes formed a committee for racial and social justice initiated by one of its dynamic young members. When this committee suggested that Black members be promoted to the Board of this organization they were told that none were “qualified”, although two Black members had held important positions for decades in professional sports. In less than a year the committee itself was disbanded by the Board, thanked politely, and informed that its “important work” was completed. Soon afterward the organization distributed new “ethics” guidelines, requiring that members refrain from criticizing the organization and from discussing differences of opinion outside of official meetings. A series of steps to investigate and punish violators was appended.

Polite talk, the sudden application of new rules, double standards, censorship, and ostracism are some of the things you may encounter when you actively attempt to remedy racism within your organizations. But within these organizations you will also find allies of all backgrounds with whom to join forces for support and action.

## See the blackness and see through the blackness

The doctor who says “I don’t see color” is stripping Black patients of an aspect of their identity. In taking account of a patient’s blackness the definition is theirs, however, not the doctor’s. Johnson was explicit about the value he placed on oral history and its roots in his culture. Kendi, whose reflections on racism are wrapped around his evolving identity as a Black man, described the poles of precocious activism, racial “insecurity” and racial “conceit” that he visited along the way [43]. Blackness is not a thing that happens to someone, it is a multifaceted endowment that evolves over time. Its character and degree of relevance is for the person to decide.

### Clinical scenario 3

A young professional basketball player is advised by the management of his team to consult with a sports psychologist or psychiatrist. Although the athlete trains in a diligent manner, he is frequently observed to “tune out” for short periods in the middle of practice, and this is impeding his development as an athlete. He chooses to see a psychiatrist unconnected with the team who, because of the absence of explicit drug or behavioral violations, is only asked to certify attendance at several sessions.

The initial sessions consist primarily of playful banter, with the athlete commenting on the psychiatrist’s dress, teaching him how to fist bump correctly, translating expressions that the psychiatrist would not understand (e.g. “don’t leave me on read”), and pointing out his apparent limitations as someone old, lame, and white. Although he mentions that his father “is not around,” any attempt to explore this is evaded with vague references such as “you know how it is”. The psychiatrist senses that he is being tested.

Between the second and third sessions the psychiatrist happens to attend a game with a friend, sitting about ten rows from the floor. During half-time a player not dressed for the game tosses rolled t-shirts into the stands as souvenirs, and one of these heads for the psychiatrist. With exaggerated casualness the psychiatrist extends one arm, catches the t-shirt in his hand, and holds the position briefly. The patient, who by then is warming up on the floor, catches sight of the event, smiles and gives the eyeball gesture.

The mood of the next meeting is decidedly different. In a series of quiet memories the athlete speaks freely of his father: Dad at his games in youth ball, Dad at grandmother’s house on Thanksgiving, Dad at the Emergency Room with the patient or with his sister, Dad expounding his philosophies, Dad brooding with unknown thoughts, and Dad making jokes. He describes his father as essentially a loving and “humble” man, perhaps troubled in ways that he kept to himself, but utterly devoted to his children until shortly before the season began when he passed away prematurely and unexpectedly.

## Conclusion

The basic phenomena that we encounter in therapy with Black athletes, the variety of possible clinical settings, the principles that guide our work, and the interventions that we employ are all identical to those that define our work with any athlete under our care. Encounters outside of the office, for example, are commonplace in sports psychiatry and may contribute to the building of trust, as happened with the basketball player mentioned above. Therapy is therapy.

Race, however, injects an additional factor. Race can be woven into the therapeutic conversation variously as an essential truth, an ancillary element, or, like the matador’s cape, a deception. Until racism goes away it is safe to say that all of us who work with athletes will be required periodically to pass through its filter on the way to providing meaningful clinical care.

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